SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*44588*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*National Association of Realtors*		
Project Name/Number:	*National Association of Realtors/National Association of Realtors*		

Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: National Association of Realtors	SERFF Tr Num: AMFA-126386513	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 44588
Sub-TOI: H10G.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Janis Landon	Disposition Date: 01/15/2010
	Date Submitted: 01/14/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: National Association of Realtors	Status of Filing in Domicile: Not Filed
Project Number: National Association of Realtors	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 01/15/2010	Explanation for Other Group Market Type:
	State Status Changed: 01/15/2010
Deemer Date:	Created By: Janis Landon
Submitted By: Janis Landon	Corresponding Filing Tracking Number:

Filing Description:

RE: Request for Review - Eligibility of a Group under §23-86-106(2)(A)
National Association of Realtors

Dear Sir/Madam:

Enclosed for your review and approval is the above captioned out-of-state group. Ameritas Life Insurance Corp. (“Ameritas”) is an Arkansas licensed insurer and has recently issued a group policy providing dental benefits to the members of the National Association of REALTORS.

SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
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Project Name/Number:	*National Association of Realtors/National Association of Realtors*		

Ameritas has requested and reviewed the By-Laws of the Association. A copy has been attached for your review. In addition, Ameritas also reviewed the statutory provisions of Arkansas Code to ensure that this potential group constituted an eligible group under §23-86-106.

Specifically, under Arkansas §23-86-106(2)(A), an eligible group is defined as an association, including a labor union, which shall have a constitution or by-laws and the Insurance Commissioner finds, regardless of where the association is domiciled or does business, which has been organized and is maintained in good faith for purposes other than that of obtaining insurance or insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

Therefore, Ameritas is requesting the Department’s review and approval of this group as an eligible group under §23-86-106(2)(A) of Arkansas Code. The by-laws confirm that the association meets all of the above requirements and Ameritas is confident that the Commissioner will find that the issuance of the policy is not contrary to the best interest of the public and the issuance of the policy would meet result in economies of acquisition or administration. Ameritas represents that the benefits of the policy are reasonable in relation to the premium charged.

The National Association of Realtors was founded as the National Association of Real Estate Exchanges on May 12, 1908 at the YMCA Auditorium in Chicago, IL. With 120 founding members, 19 Boards, and one State Association, the National Association of Real Estate Exchanges' objective was "to unite the real estate men of America for the purpose of effectively exerting a combined influence upon matters affecting real estate interests."

In 1916, the National Association of Real Estate Exchange's name was changed to The National Association of Real Estate Boards (NAREB). That same year, the term “REALTOR,” identifying real estate professionals who are members of the National Association and subscribers to its strict Code of Ethics, was devised by Charles N. Chadbourn, a past president of the Minneapolis Real Estate Board.

In 1972, the name of the National Association of Real Estate Boards was changed to the National Association of REALTORS® (NAR).
The Association became the largest trade association in the United States in the early 1970s, with over 400,000 members. Today, the National Association of REALTORS® has over 1.2 million members, 54 State Associations (including Guam, Puerto Rico, and the Virgin Islands) and more than 1,400 local Associations. NAR was incorporated in Illinois.

NAR’s mission is to help its members become more profitable and successful. The association was formed to:
• To provide a facility for education, research and exchange of information for those engaged in the recognized branches of the real estate business, including brokerage, management, mortgage financing, appraising, counseling, land development and building, and education and research in real estate, in the United States of America, its insular possessions and the Commonwealth of Puerto Rico, for the purpose of raising the standards of real estate practice and

preserving the right of property ownership in the interest of the public welfare can directly benefit from corporate discounts on products and services that are used on a regular basis.

• To promote and maintain high standards of conduct in the transaction of the real estate business;

• To formulate and promulgate a Code of Ethics for the members of the National Association;

• To license its members the right to display the emblem seal of the National Association and the right to use the terms REALTOR®, REALTORS®, or REALTOR-ASSOCIATE® which terms are hereby defined as designating a person or persons engaged in the real estate business who is a Board Member or Individual Member of the NAR .

• To inform the public of the advantages of transacting business with REALTORS®, and to encourage the use by Members of the term REALTOR® and the emblem seal.

Ameritas has already filed the group policy with Illinois and a copy is attached for your reference. Following approval by your Department, Ameritas will issue a certificate form to any Arkansas members of this group under certificate form 9021 Rev. 03-08. The content of this certificate form was previously approved by the Department on August 4, 2009 for true employer groups. There are seven different plan options.

The current address for this out-of-state group is:
National Association of Realtors
430 North Michigan Avenue
Chicago, Illinois 60611-4087

The National Association does not maintain an office in the state of Arkansas. There are member boards in the state of Arkansas. There is a state association and 37 local associations. Each member board is a separate corporation related to NAR by membership as described in the Constitution. The officers and committees of the state association and the local association are related to those organizations and have no status in NAR except as members.

NAR assesses dues to member boards which are calculated based upon the number of members and non-member licensees affiliated with members times $80. There is currently a special assessment in place to finance a national television and radio public awareness campaign of $35 per member. They do not receive any compensation by the insurer issuing the contracts to their members.

NAR carries on all of the usual and customary activities associated with a professional trade association. Some are described below and others are discussed in NAR’s membership kit.

Outlined below are just a few of the many benefits members receive:

• REALTOR.org/NARHelpsYou: Find dozens of helpful products and resources, including the just-released FHA Toolkit, for free online or for purchase at a steep discount at the REALTOR® store.

• REALTOR® Magazine: A $56 value, the magazine’s valuable content, business tips and tools are provided to you free

every month as a member.

• Legislative Affairs: NAR is in Washington, fighting every day to protect their profession, and RPAC contributions provide funds to gain influence with decision makers—all of which result in value to its members every day.
• Code of Ethics: What sets REALTORS® apart from the rest—and protects consumers as we navigate through the process together. Every member is required to complete 2 ½ hours of Ethics training every four years.
• Public Awareness Campaign: In its 11th year, the campaign is positively affecting the how consumers view REALTORS®, including educating them on the important distinction between working with a REALTORS® and someone who is not a member.
• Professional Development: Numerous certifications and designations are available to members to further his/her expertise.
• Online Resources: A member can post his/her listings for free on REALTOR.com, the #1 most visited homes-for-sale site. And REALTOR.org provides the member with a wealth of information and the latest industry news online, any time, always free to the member.
• REALTORS are individuals who are engaged in any one of several different aspect of the real estate business who have committed to conduct that business in a manner consistent with NAR's Code of Ethics and have agreed to abide by the Bylaws, rules and regulations of the national, state and local association of REALTORS. In addition, local association may precondition membership upon an applicant being properly licensed or certified by the appropriate real estate commission or appraisal board, the applicant not having been sanctioned for conduct involving unprofessional conduct, including violations of the Code of Ethics as determined by other member boards, completion of a orientation program and no recent or pending bankruptcy.

NAR does not directly recruit individuals for membership. This may be done by local associations in their communities. If lists are used the most likely source would be the state government's list of licensees.

There are 7624 REALTORS in Arkansas, but Ameritas does not give out that list. There are currently no members that obtain Ameritas' dental benefits. The effective date of these benefits will be 01/01/2010.

This form is in final print. When scored with the policy, this form achieves a 50 on the Flesch Readability Scale.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,

Janis Landon
Senior Contract Analyst

SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*44588*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*National Association of Realtors*		
Project Name/Number:	*National Association of Realtors/National Association of Realtors*		

Company and Contact

Filing Contact Information

Janis Landon, Contract Analyst
5900 O Street
P O Box 81889
Lincoln, NE 68501-1889

jlandon@ameritas.com
800-745-1112 [Phone] 87997 [Ext]
402-467-7956 [FAX]

Filing Company Information

Ameritas Life Insurance Corp.
5900 O Street
P O Box 81889
Lincoln, NE 68501-1889
(800) 756-1112 ext. [Phone]

CoCode: 61301
Group Code: 943
Group Name:
FEIN Number: 47-0098400

State of Domicile: Nebraska
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	$0.00	01/14/2010	

SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/15/2010	01/15/2010

SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
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Disposition

Disposition Date: 01/15/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Bylaws	Approved-Closed	Yes
Supporting Document	Marketing Information	Approved-Closed	Yes
Supporting Document	Master Policy	Approved-Closed	Yes
Supporting Document	Financial Statement	Approved-Closed	No
Supporting Document	Board/Officer Information	Approved-Closed	Yes

SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
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Project Name/Number:	*National Association of Realtors/National Association of Realtors*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Bypassed - Item:	Flesch Certification	Approved-Closed	01/15/2010
Bypass Reason:	Bypass Reason. This is an association filing. No forms are being filed for approval, as the certificate that will be issued has been previously approved.		
Comments:			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	01/15/2010
Comments:			
Attachment:			
NAR Signed Application.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Bylaws	Approved-Closed	01/15/2010
Comments:			
Attachment:			
2009 Constitution & Bylaws.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Marketing Information	Approved-Closed	01/15/2010
Comments:			
Attachment:			
NAR Marketing Info.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Master Policy	Approved-Closed	01/15/2010
Comments:			

SERFF Tracking Number:	*AMFA-126386513*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*44588*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*National Association of Realtors*		
Project Name/Number:	*National Association of Realtors/National Association of Realtors*		

Attachment:

010-350635ep.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Board/Officer Information	Approved-Closed	01/15/2010

Comments:

Attachments:

2010 NAR Leadership.pdf

2008 Annual Report final reduced part i.pdf

2008 Annual Report final reduced part ii.pdf

NOV 20 2009

application

See reverse side for additional information.

AMERITAS LIFE INSURANCE CORP.
Lincoln, NE

for association group dental and/or vision insurance

1. Applicant's Legal Name National Association of REALTORS®

2.
60611-4087
P.O. Box / ZIP Code
430 North Michigan Ave.
Street Address
Chicago, IL 60611-4087
City / State / ZIP
Phone No. Fax No.
E-mail Address Tax I.D. No.

3. What is the type and occupational nature of the association?
(Please provide copy of association bylaws.)
XTrade Real estate
I Professional
I Other

4. Eligibility
Total number of eligible employees 1,200,000
Employees in waiting period . . . . . N/A

5. Are any Association chapters, classes of members or locations excluded? . . . . . I Yes I X No
Are domestic partners included? . . . . . I X Yes I No
Are retirees included? . . . . . I X Yes I No
(If yes, please use reverse side for explanation.)

6. Are employees of Association members or Non-Association members eligible to participate? . . . . . I X Yes I No
(If yes, please use reverse side to list name and location.)

7. Who is responsible for eligibility verification?
I Association Office I Broker/TPA
IX Other SASid

8. The following coverages are applied for:
Employee & Dependents Benefits
X Dental X Orthodontia X Eye Care
I Other
Employee Only Benefits
I Dental I Orthodontia I Eye Care
I Other

9. Member Participation/Contribution
XMembers pay 100% of premiums
I Premiums paid by Association dues
I Other:

10. Dependent Participation/Contribution
XMembers pay 100% of premiums
I Premiums paid by Association dues
I Other:

11. Waiting Period
_____ for those employed on or before the policy effective date.
Next Day for those employed after the new policy effective date.

12. Effective Date and Termination Date
I Immediate
I First of Month Effective date / End of Month Termination date
X Other Next Day Coverage

13. Premium Payment Mode (In advance)
X Monthly I Quarterly I Semi-Annual I Annual

14. If a policy effective date is other than first of the month, is a first-of-the-month premium due date desired? . . . . . X Yes I No

15. Billing Options
I Home Office
XThird-Party Administration (TPA must be approved by us.)
Shannon Kennedy, SASid
Contact Name
President
Title
462 Midland Road
Street Address
Janesville, WI 53546
City / State / ZIP
608-756-2290
Phone No. Fax No.
admin@sasid.com
E-mail Address

16. Policy and Certificate Delivery (select one)
A. eCert*/ePolicy (*generic cert, non-personalized)
XXvia PDF format sent via e-mail to:
Admin@sasid.com
I via eService and member portal
B. Paper policy/personalized certificates
I Initial employees only
I Subsequently added employees
Note: eCert will be available on member portal for all members.

17. Insurance requested on this application will replace the coverage(s) checked.

Coverages: I Dental I Orthodontia I Eye Care

I Other _____

Name of Current Carrier _____

Policy No. _____

I Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

I It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.

_____ _____

Termination Date Original Effective date

Item 5: Exclusions

a. Classes, include reason for exclusion.

Association Executives (AE) and NAR staff.

b. Locations, if location is different from applicant's, list city and state.

Plan Design and Proposed Rates: See attached Plan Summary

Additional Remarks: 2 year rate guarantee. Exclusive rates and plan designs for members of the NAR. Bonus benefits: cosmetic, orthodontia, LASIK & dental rewards.

Agreements

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Statements

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (See state-specific statements.) • **Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents. • **Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts for information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. • **Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. • **Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. • **Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. • **Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. • **Note for New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. • **Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

☐ **If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit PPO providers, check this box.**

Signed at: City Chicago State IL Date 11/18/2009

Signed by: (Policyholder ~~Representative~~)

Printed name and title Robert A. Goldberg Senior VP

Signature [signature]

Soliciting Agent: I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name Shannon Kennedy, SASid For FL agents only, provide FL license # _____

Signature [signature]

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? ☐ Yes ☒ ~~No~~ XX If yes, then amount $ N/A .

Check received by (agent) N/A **Authorized by** (policyholder) _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

2009 Constitution and Bylaws

of the

* NATIONAL ASSOCIATION OF REALTORS®

Incorporating Amendments and Interpretations effective on or before November 16, 2007.

The Constitution and Bylaws were adopted at San Francisco, California, May 31, 1922. Since that adoption they have from time to time been revised; their last revision having been made at the Annual Convention in Orlando, Florida, on November 11, 2008.

* Formerly National Association of Real Estate Boards. Name change authorized at National Convention, Honolulu, Hawaii, November 15, 1972.

NATIONAL ASSOCIATION OF REALTORS®
430 North Michigan Avenue
Chicago, Illinois 60611-4087

2009 Constitution and Bylaws

of the

NATIONAL ASSOCIATION OF REALTORS®

Table of Contents

CONSTITUTION

ARTICLE I

NAME

The name of the organization shall be NATIONAL ASSOCIATION OF REALTORS®.

ARTICLE II

OBJECTS

The objects of the National Association shall be:

SECTION 1. To provide a facility for education, research and exchange of information for those engaged in the recognized branches of the real estate business, including brokerage, management, mortgage financing, appraising, counseling, land development and building, and education and research in real estate, in the United States of America, its insular possessions and the Commonwealth of Puerto Rico, for the purpose of raising the standards of real estate practice and preserving the right of property ownership in the interest of the public welfare;

SECTION 2. To promote and maintain high standards of conduct in the transaction of the real estate business;

SECTION 3. To formulate and promulgate a Code of Ethics for the members of the National Association;

SECTION 4. To license its members the right to display the emblem seal of the National Association and the right to use the terms REALTOR®, REALTORS®, or REALTOR-ASSOCIATE® which terms are hereby defined as designating a person or persons engaged in the real estate business who is a Board Member or Individual Member of the NATIONAL ASSOCIATION OF REALTORS®.

SECTION 5. To inform the public of the advantages of transacting business with REALTORS®, and to encourage the use by Members of the term REALTOR® and the emblem seal.

ARTICLE III

MEMBERSHIP

SECTION 1.
(A) The Members of the National Association shall consist of seven classes: (1) Member Boards, (2) Board Members, (3) Individual Members, (4) National Affiliate Members, (5) International Members, (6) Affiliated Institutes, Societies and Councils, and (7) Distinguished Service Award Recipients.

(B) Member Boards shall consist of (1) local real estate boards or associations or Boards or Associations of REALTORS® (hereinafter referred to as local Boards), which shall include city, county, inter-county or inter-state Boards, and also (2) state associations as provided in Section 5 of this Article, all of the REALTOR® Members and REALTOR-ASSOCIATE® Members of which shall hold membership in the National Association through such local board, or state association, as the case may be.

(C) Board Members shall be either REALTOR®, REALTOR-ASSOCIATE® or Institute Affiliate Members in good standing.

1. REALTOR® Members shall be:

(a) principals of real estate firms, or individuals in position of management control on behalf of principals who are not physically present and engaged in the real estate business in connection with the firm's office or individuals employed by or affiliated as independent contractors with REALTOR® principals of real estate firms, and who are deemed qualified for REALTOR® membership by: (a) a local Board within the state in which the real estate firm is located; or (b) a local Board within a state whose border is contiguous with that state; or (c) if the real estate firm is located outside the jurisdiction of any local board, by the state association within whose territory the real estate firm is located having an effective membership agreement with the National Association as provided in Article XV, Section 2. Each sole proprietor, partner or corporate officer of the real estate firm who is actively engaged in the real estate business within the state where applying for membership or within the state in which the real estate firm is located shall be required to become a REALTOR® member if any other principal of such firm, partnership or corporation is a REALTOR® Member with those

states, provided, however, in the case of a real estate firm, partnership or corporation whose business activity is substantially all commercial, each sole proprietor, partner, corporate officer actively engaged in the real estate business in connection with the same office or any other offices within the jurisdiction of the local board in which one of the firm's principals holds REALTOR® membership shall also be required to become a REALTOR®.

(b) corporate officers of a national real estate brokerage franchise organization with at least one hundred fifty (150) franchisees located within the United States , its insular possessions and the Commonwealth of Puerto Rico, the principal broker of not less than one hundred and fifty of which are REALTOR® Members of a Member Board of the National Association. Up to three (3) of the real estate brokerage franchise organization's corporate officers may hold REALTOR® Membership pursuant to this provision of the Constitution, provided however, that at least one of the three must be the Chief Executive Officer or Principal Operating Officer of the real estate brokerage franchise organization.

Each corporate officer making application to hold membership in the National Association pursuant to this provision of the Constitution shall designate for the National Association a local board located within the state in which the corporate officer's principal place of business is located which shall be considered that corporate officer's primary Board and the corporate officer shall pay dues, initiation and processing fees to that local Board in the same manner and in the same amount as are paid to that local Board by all other REALTOR® Members of that local Board. Upon approval of the corporate officer's application for membership by the Board of Directors of the National Association, the National Association shall notify the primary Board identified by the corporate officer of the name and address of the corporate officer to which the local Board shall direct statements for dues, initiation or other processing fees normally assessed to the local Board's REALTOR® Members and such other correspondence or information as the local board sends to its REALTOR® Members. Upon payment of initial dues and any applicable initiation and processing fees, the applicant shall be a member of that local Board, the state association within whose jurisdiction that local Board is located and the National Association.

2. REALTOR-ASSOCIATE® Members shall be those independent contractors and salesmen who are affiliated with or employed by a REALTOR® Member or a firm, partnership, or corporation of which any REALTOR® Member is a sole proprietor, partner or officer, who are actively engaged in the real estate business and who are deemed qualified for REALTOR-ASSOCIATE® membership by a local board within the state in which the independent contractor or salesman is actively engaged in the real estate business or within a state whose border is contiguous with that state, or if the real estate firm is located outside the jurisdiction of any local board, by the state association within whose territory the independent contractor or salesman is actively engaged in the real estate business having an effective membership agreement with the National Association as provided in Article XV, Section 2.

3. Individuals who are employed by or affiliated as independent contractors with the REALTOR® principals of a real estate firm shall be eligible to be considered for primary membership as REALTORS® or REALTOR-ASSOCIATE®s only in those member boards in which a principal of the real estate firm or an individual in a position of management control on behalf of a principal who is not physically present and engaged in the real estate business in connection with the firm's real estate office holds REALTOR® membership.

4. (a) Institute Affiliate members shall be individuals who hold a professional designation awarded by an Institute, Society or Council affiliated with the NATIONAL ASSOCIATION OF REALTORS® that addresses a specialty area other than residential brokerage or individuals who otherwise hold a class of membership in such Institute, Society or Council that confers the right to hold office. Any such individual, if otherwise eligible, may elect to hold REALTOR® or REALTOR-ASSOCIATE® membership, subject to payment of applicable dues for such membership.

(b) Local boards will establish the rights and privileges to be conferred on Institute Affiliate Members except that no Institute Affiliate Member may be granted the rights to use the term REALTOR®, REALTOR-ASSOCIATE, or the REALTOR® logo; to serve as President of the local board; or to be a Participant in the local board's multiple listing service.

(c) Institute Affiliate Member dues shall be as established in Article II of the National Association’s Bylaws. Member Boards may not establish any additional entrance, initiation fees or dues for Institute Affiliate members, but may provide service

packages to which Institute Affiliate members may voluntarily subscribe.

5. As used herein:

(a) the term "real estate business" shall include real estate brokerage, management, appraising, land development or building.

(b) the term "primary membership" shall refer to an individual's membership in a member board which includes that individual in its calculation of dues paid to the National Association as provided for in Article II, Section 1 of the National Association's Bylaws. The individual shall be a "primary member" of that member board.

(D) Individual Members shall be persons who are elected to membership under the provisions of Section 7 of this Article.

(E) International Members shall be persons who are elected to membership under the provisions of Section 8 of this Article.

(F) Affiliated Institutes, Societies and Councils shall be those formed by the National Association pursuant to Article XIII, Section 1 of this Constitution

(G) In addition, those persons who are currently employed in an executive, administrative or management capacity by a Member Board of the National Association, or by an Institute, Society or Council of the National Association, shall be eligible for Individual Membership without payment of dues and shall be entitled to all rights and privileges of Individual Membership except the right to use the term REALTOR®.

SECTION 2.

(A) Only one local board in any municipality shall be elected a Member Board of the National Association, except as provided in Sections 3 and 4 of this Article, or otherwise approved by the Board of Directors of the NATIONAL ASSOCIATION OF REALTORS®.

(B) A local board may accept for primary membership individuals whose principal place of business is situated within the territory of the state in which the local board's jurisdiction is located or any state contiguous to that state, provided however, that individuals who are employed by or affiliated as independent contractors with the REALTOR® principals of a real estate firm shall be eligible to be considered for primary membership as REALTORS® or REALTOR-ASSOCIATE®s only in those local boards in which a principal of the real estate firm or an individual in a position of management control on behalf of a principal who is not physically present and engaged in the real estate business in connection with the firm's real estate office holds REALTOR® membership. A local board may accept for secondary membership any REALTOR® or REALTOR-ASSOCIATE® who holds primary membership in another member board. An individual holding secondary membership in a local board is not required to hold secondary membership in the state association in which the local board holds membership.

SECTION 3. If territory is annexed by a municipality in which there is a local board which is a Member Board, such annexation shall not automatically enlarge the jurisdiction of such board if the enlargement would infringe upon the jurisdiction of another such local board; however, the Board of Directors may, in its discretion, provide for the retention or modification of the respective jurisdictions of such boards, in the absence of an agreement between them.

SECTION 4. The Board of Directors may, at its discretion, approve the establishment of Commercial Boards of REALTORS®. The rights and responsibilities of the Boards shall be set forth in this Constitution and the Bylaws of the National Association and in accordance with policies approved by the Board of Directors and as amended from time to time.

SECTION 5.

(A) State Associations having membership agreements with the National Association as provided in Article XV, Section 2, of this Constitution may be elected to membership in the National Association in order to integrate more closely the work of local, state and national bodies, to further the purposes contemplated by said Article, and to afford an opportunity for individuals engaged in the real estate business in areas within the state but outside the jurisdiction of a local board to become members of the National Association, subject to its standards, and to be represented therein.

(B) Such state associations shall be elected to membership only upon the following conditions:

1. Only one state association shall be elected from a given state;

2. Such state association so elected may accept for primary membership individuals whose principal place of business is situated in territory within the state which is not within the jurisdiction of any local board holding membership in both such state association and the National Association and for secondary membership any REALTOR® or REALTOR-ASSOCIATE® who holds primary membership in another state association or a local board whose jurisdiction is located in territory outside of the state;

3. Such state association so electing individuals agrees to be responsible for the enforcement of the Code of Ethics of the National Association with respect to such individuals;

4. Such state association shall have the same right to control the use of the terms REALTOR®, REALTORS®, and REALTOR-ASSOCIATE® in its territory as any local board has within its jurisdiction;

5. Such state association electing individuals to membership agrees to pay dues for them in the same manner as a local board pays dues for its REALTOR® Members and REALTOR-ASSOCIATE® Members.

6. Whenever the term "Member Board" is used in this Constitution and Bylaws, it shall be held to include state associations elected under the terms of this section.

(C) Any state association so elected shall be entitled to one vote as such and to an additional vote for each of its Board Members upon the same basis as local boards for their Board Members under the provisions of Article IX of this Constitution.

SECTION 6. All Member Boards must comply with the minimum service criteria established by the Board of Directors.

Any Member Board that fails to satisfy the minimum service criteria may, after due notice and opportunity for hearing, be expelled by the Board of Directors from membership in the National Association.

Each State Association shall enforce the minimum service criteria for local Boards and Associations within the state. Any State Association which fails to enforce the minimum service criteria may, after due notice and opportunity for hearing, be expelled by the Board of Directors from membership in the National Association.

SECTION 7. In areas of states where there is no state association having a membership agreement with the National Association, as provided in Section 5 of this Article, and where there is no Member Board, or which areas have not been designated as within the territorial jurisdiction of any Member Board, the Board of Directors may elect any individual engaged in the real estate business as a principal, partner or officer of a corporation as an individual Member. In the case of each application, the nearest Member Board shall be consulted. The rights, privileges and obligations of such Individual Members shall be the same as those of REALTOR® Members, each such Individual Member being a delegate to any meeting of the members of the National Association and entitled to one vote; but in the event of subsequent admission to membership of a local board or state association as a Member Board, such Individual Member shall thereafter be entitled to membership only by virtue of membership in such Member Board.

SECTION 8.

(A) International Affiliate Organizations shall be associations in the real estate field outside of the United States, its insular possessions, and the commonwealth of Puerto Rico, with which the National Association enters into International Affiliate Agreements that provide for exchange representation and other mutual benefits, and for the adoption and enforcement by the International Affiliate Organization of a Code of Ethics approved by the National Association.

(B) In any country where the National Association has entered into an International Affiliate Agreement with a real estate organization, only those persons engaged in the real estate business in that country who have obtained membership in such Organization shall be eligible for International REALTOR® Membership in the National Association. Such International REALTOR® members may be licensed to use the term REALTOR® and other marks, but may not vote or hold office in the National Association.

(C) Persons engaged in the real estate business in any country where the National Association has not entered into an International Affiliate Agreement with a real estate organization in said country, or persons who are not eligible for membership in an International Affiliate Organization in any country where the National Association has an agreement with such an organization, shall be eligible for

International Subscriber membership in the National Association. Such International Subscriber members may neither be licensed to use the term REALTOR® or other marks, nor vote or hold office in the National Association.

SECTION 9 . Individuals who have received the Distinguished Service Award shall be life members of the National Association and shall not pay National Convention registration fees.

SECTION 10 . A REALTOR® Member who has held membership in the National Association as a REALTOR®, REALTOR-ASSOCIATE®, or both, for a cumulative period of forty (40) years, upon certification by the Board of Directors shall be designated "REALTOR® EMERITUS." An individual who has been affiliated with a firm comprised of REALTOR® members for forty (40) years or more, but who was ineligible for REALTOR® or REALTOR-ASSOCIATE® membership for any portion of that time on the basis of sex, national origin, marital status or other basis now prohibited by the Bylaws of the National Association shall be eligible for REALTOR® Emeritus status.

SECTION 11. Individuals employed by the national or regional organizational headquarters of a corporation engaged in real estate activities or activities allied with real estate and who may be licensed or unlicensed may be elected to National Affiliate Membership in the National Association, provided the individual does not personally provide real estate services to persons or entities other than the employing company. National Affiliate Members shall have such privileges, duties, and rights of membership, and shall pay such dues as determined by the Board of Directors, but shall not be entitled to vote, hold office or use the terms REALTOR® or REALTOR-ASSOCIATE®. National Affiliate Members shall be entitled to hold membership in the Institutes, Societies and Councils of the National Association, but if they desire to apply for or maintain a designation available through an Institute, Society or Council, they must hold a form of membership in the local board. If membership is not available in the local Board, the individual must hold membership in the State Association. If membership is not available through the State Association, the individual may apply for or maintain a designation from an Institute, Society or Council based on National Affiliate Membership.

SECTION 12. REALTOR® Members holding membership pursuant to Section 1(C) 1.(b) of this Constitution shall be Board Members of the local Board designated by them pursuant to that section of the Constitution and of the state association within whose jurisdiction that local Board is located and shall enjoy all of the rights, privileges and obligations, including compliance with the Code of Ethics, of other REALTOR® Members of that state association and local Board except: obligations related to mandatory education, meeting attendance, or indoctrination classes or similar requirements; the right to use the term REALTOR® in connection with their franchise firm's name; and the right to hold elective office in the local Board or state association.

ARTICLE IV

BOARD OF DIRECTORS

SECTION 1. The government of the National Association shall be vested in a Board of Directors composed of the following ex officio Directors:

(A) The President, President-Elect, First Vice President and Treasurer of the National Association. Any person, having been duly elected as an officer of the National Association, and who, as a consequence thereof, is an ex officio member of the Board of Directors and/or the Executive Committee, shall continue to serve as a member of the Board of Directors and/or the Executive Committee for the balance of the then current elective year in the event the office to which they had been elected is eliminated.

(B) Up to twenty-four (24) members of the Executive Committee who are not already members of the Board of Directors selected by the incoming President provided that such member of the Executive Committee has not resigned a Directorship, the term of which would have coincided in whole or in part with his term appointment to the Board of Directors;

(C) The Presidents of the Institutes, Societies and Councils of the National Association;

(D) The former Presidents of the National Association who continue to be affiliated with their respective local boards and active in the National Association;

(E) The Presidents of state associations and of the Washington (D.C.) Association of REALTORS®, the Guam Board of REALTORS®, the Puerto Rico Association of REALTORS®, and the Virgin Islands Territorial Association of REALTORS®;

(F) The Presidents of the International Affiliate Organizations, or their designees, if so provided by reciprocal agreement;

(G) The Vice President and Liaison to Committees who is not a Director at Large or otherwise a Director ex officio, provided the Vice President and Liaison to Committees has not resigned a Directorship the term of which would have coincided in whole or in part with the term as the Vice President and Liaison to Committees;

(H) The Vice President and Liaison to Government Affairs who is not a Director at Large or otherwise a Director ex officio, provided the Vice President and Liaison to Government Affairs has not resigned a Directorship the term of which would have coincided in whole or in part with the term as the Vice President and Liaison to Government Affairs;

(I) The Regional Vice Presidents of the National Association;

(J) The Political Fundraising Chair who is not a Director at Large or otherwise a Director ex officio, provided the Political Fundraising Chair has not resigned a Directorship the term of which would have coincided in whole or in part with the term as the Political Fundraising Chair;

(K) The Member Mobilization Chair who is not a Director at Large or otherwise a Director ex officio, provided the Member Mobilization Chair has not resigned a Directorship the term of which would have coincided in whole or in part with the term as the Member Mobilization Chair;

(L) A REALTOR® or REALTOR-ASSOCIATE® who also holds membership in the National Association of Real Estate Brokers, as recommended by the President of that Association and to be appointed by the incoming President of the NATIONAL ASSOCIATION OF REALTORS®.

(M) Four Association Executives consisting of two from local associations, one from a state association, and one from a regional multiple listing service, selected by the incoming President;

(N) Up to two (2) REALTORS® or REALTOR-ASSOCIATE®s who are members of a commercial overlay board selected by the incoming President;

(O) Up to three (3) REALTORS® or REALTOR-ASSOCIATE®s appointed by the incoming President to represent specialties within the real estate business;

(P) Up to ten (10) representatives of organizations not affiliated with the National Association selected by the President and approved by the Leadership Team. Representatives may be selected and approved at any time during an elective year and shall serve for the balance of that elective year;

(Q) The Chairman of each of the Board and State Forums who is not a Director at Large or otherwise a Director ex officio, provided such Chairman has not resigned a Directorship the term of which would have coincided in whole or in part with the term of his chairmanship, provided that if there are more than ten (10) State and Board Forum Chairmen the incoming President shall designate from among the Chairmen up to ten (10) to serve as Directors;

(R) Each Committee Liaison who is not a Director at Large or otherwise a Director ex officio, provided such Committee Liaison has not resigned a Directorship the term of which would have coincided in whole or in part with the term as a Committee Liaison, provided that if there are more than seven (7) Committee Liaisons the incoming President shall designate from among the Committee Liaisons up to seven (7) to serve as Directors;

(S) Recipients of the Distinguished Service Award who continue to be affiliated with their respective local board shall serve as Directors;

(T) Each local board within the fifty states, the District of Columbia, Guam, Puerto Rico or the Virgin Islands with a membership of 2000 or more shall be entitled to a number of Directors determined by dividing the membership of the local board by the number 2000 and rounding any resultant fraction to the next lower whole number. Each local board entitled to Directors pursuant to this subparagraph shall notify the National Association of the names of the REALTORS® and REALTOR-ASSOCIATE® s designated to serve as Directors during the next elective year prior to October 1st.

(U) Each of the fifty states and the District of Columbia, Guam, Puerto Rico and the Virgin Islands ("state associations") shall be entitled to two Directors plus an additional number of Directors

determined by subtracting the number 4000 from the membership within the state association, dividing any remainder greater than zero by the number 2000 and rounding any resultant fraction to the next lower whole number, provided, however, the number of additional Directors to which the state association is entitled shall be reduced by the number of Directors allocated to local boards within the same state association under subparagraph (T) hereof. In the case of a local board with assigned territorial jurisdictions within two or more state associations, the number of additional Directors to which a state association is entitled shall be reduced by a number equal to the number of Directors the local board would be entitled to under subparagraph (T) hereof based upon the number of primary members of the local board who also hold primary membership in the state association. Each state association entitled to Directors pursuant to this subparagraph shall notify the National Association of the names of the REALTORS® and REALTOR-ASSOCIATE®s designated to serve as Directors during the next elective year prior to October 1st.

(V) Each national real estate brokerage franchise organization with at least one hundred fifty (150) franchisees located within the United States, its insular possessions and the Commonwealth of Puerto Rico, the principal broker of not less than one hundred fifty of which are REALTOR® members of a Member Board of the National Association shall designate one Director who must be a principal, partner or corporate officer of the national real estate brokerage franchise organization and hold REALTOR® or REALTOR-ASSOCIATE® membership in a Member Board of the National Association.

(W) Each of the seventy -five (75) largest firms, partnerships or corporations in the real estate business and doing business within the geographic areas described in Paragraph 1(T) hereof shall designate one Director who must be a principal, partner or corporate officer of the firm, partnership or corporation and hold REALTOR® or REALTOR-ASSOCIATE® membership in a Member Board of the National Association. The largest real estate firms, partnerships, or corporations shall be identified by determining those with the greatest number of REALTORS® and REALTOR-ASSOCIATE®s employed by or affiliated with a principal, partner, corporate officer or branch office manager of the firm, partnership or corporation. In making the determination of the largest firms, partnerships or corporations, all real estate businesses operating under common control, regardless of their business structure, shall be considered a single firm, partnership or corporation.

(X) "Membership" as used in this Section shall mean in the records of the National Association the combined number of REALTOR® and REALTOR-ASSOCIATE® members holding primary membership in a Member Board within the geographic area as of the July 31st of the year of the election.

(Y) All ex officio Directors shall serve terms of one year or until their successors are selected except those designated by the states pursuant to subparagraph (U) hereof, who shall serve for terms of three years or until their successors are selected.

SECTION 2. In order to maintain a balance in the expiration of the terms of Directors under Section 1(U) hereof, the state association may designate one or more such Directors serve for terms of less than three years.

SECTION 3. One-third of the whole Board of Directors shall constitute a quorum.

SECTION 4. There shall be two regular meetings of the Board of Directors in each year at a time and place fixed by the Board of Directors. Special meetings may be called by the President or by twenty-five members of the Board of Directors representing at least five states or the District of Columbia, upon due notice in writing given to each Director. Directors may unite in a petition to call such meeting or individually address written requests to the National Association. Upon receipt of such petition or written requests from the required Directors, the President shall notify each Director, in writing, of such meeting, fixing the time and place thereof not less than ten nor more than thirty days from the date of said notice.

SECTION 5. Any Director, except the former Presidents of the National Association, who shall be absent from two consecutive regular meetings of the Board of Directors shall automatically forfeit his office unless the Board of Directors, upon receipt of a written explanation for such absence satisfactory to it, shall waive this provision.

SECTION 6. The Board of Directors and the Officers shall from time to time seek the opinions and advice of Member Boards on matters of national import in such manner as may be convenient and shall consider such information in their deliberations.

ARTICLE V

EXECUTIVE COMMITTEE

SECTION 1.
(A) There shall be an Executive Committee consisting of the President; the President-Elect; the First Vice President; the Treasurer; the Regional Vice Presidents; the immediate Past President; the Vice President and Liaison to Committees; the Vice President and Liaison to Government Affairs; four other Past Presidents; twelve members who have not served as President; two members from the Real Estate Services Advisory Board; one Member Board Executive Officer; and one appointee of each of the Institutes, Societies and Councils of the National Association. The Political Fundraising Chairman and the Member Mobilization Chairman shall also serve as non-voting members of the Executive Committee.

(B) The President shall appoint, each year, two Past Presidents to serve two year terms, to succeed those whose terms expire.

(C) At the meeting of the Board of Directors during the National Convention, the President-elect shall submit to the Board of Directors six nominees, at least four of whom are Directors, one of whom may be a member who has previously served as a Director, and one of whom may be a member who has not previously served as a Director, to serve as members of the Executive Committee. The Board of Directors shall elect members of the Executive Committee from such nominations. Directors shall be elected to the Executive Committee for terms of two years to commence on the day following the official closing of the National Convention at which they are elected, six being elected each year to succeed the Directors whose terms expire. Directors so elected shall continue in office until their successors are elected and qualified. If a vacancy occurs before expiration of a term, the President shall submit to the Board of Directors the nomination of a Director to fill the unexpired term.

(D) The President shall appoint, each year, a member from the Real Estate Services Advisory Board established by the Board of Directors to serve a two year term, to succeed the member whose term is expiring.

(E) The President shall appoint, each year, a Member Board Executive Officer to serve a one year term, to succeed the one whose term expires.

(F) Each Institute, Society and Council shall designate one of its members in good standing, who is not an employee, to serve a two year term, to succeed those whose terms expire.

SECTION 2. The Executive Committee shall conduct the affairs of the National Association in accordance with the policies and instruction of the Board of Directors. The Executive Committee shall meet on the call of the President, the Board of Directors or any eleven of its members. The President shall act as Chairman of the Executive Committee. Seventeen members shall constitute a quorum.

SECTION 3. A Member who has served as a member of the Executive Committee for terms aggregating twenty (20) years shall be a member of the Executive Committee for life unless sooner terminated by resignation from the Committee or the National Association.

ARTICLE VI

ADVISORY BOARD

SECTION 1. There shall be an Advisory Board composed of all former Presidents of the National Association who continue to be affiliated with their local boards.

SECTION 2. The Advisory Board shall act in an advisory capacity to the Officers and Directors of the National Association.

SECTION 3. The Chairman shall be the second immediate Past President who is able to serve.

ARTICLE VII

OFFICERS, ELECTIVE AND APPOINTIVE - POWERS AND DUTIES

SECTION 1. The elective Officers of the National Association shall be a President, a President-Elect, a First Vice President, a Vice President from each of the Regions created by the Board of Directors, a Treasurer, and a corporate Secretary, all of whom shall serve for one year or until their successors are elected and assume office.

The President shall not be eligible for a second or subsequent election.

SECTION 2.
(A) The President shall be the chief elected officer of the National Association and shall preside at its meetings and those of the Board of Directors and Executive Committee, between the sessions of which he shall represent the Association and act in its name, subject only to its declared policies. He shall appoint all committees unless otherwise directed by the Board of Directors, shall be an ex officio member of all committees, and shall perform all other duties usual to such office.

(B) The President-Elect shall perform the duties of the President in the event of his absence or disability and shall have such other powers and duties as may be prescribed by the Board of Directors, the Executive Committee or the President. The President-Elect shall succeed to the office of the President. If the office of the President should become vacant between elections, the President-Elect shall fill the vacancy and complete the unexpired term. The President-Elect who fills a vacancy in the office of the President shall automatically become President for a full term after completion of the unexpired term.

(C) The First Vice President shall have such powers and duties as may be prescribed by the Board of Directors, the Executive Committee or the President. If the office of President-Elect shall become vacant between elections, the First Vice President shall fill the vacancy and complete the unexpired term. The First Vice President who fills a vacancy in the office of President-Elect shall automatically become President for a full term after completion of the unexpired term.

(D) In the event of the death or disability of the President and the inability or incapacity of the President-Elect and the First Vice President to succeed to such office pursuant to this section, the office of President shall be filled until the next National Convention by a person appointed by the Executive Committee.

SECTION 3.
(A) The Regional Vice Presidents shall oversee the work of the National Association in their respective Regions and act as the representative of the President in such matters as may be assigned to them.

(B) In case of a vacancy in the office of any Regional Vice President, it shall be filled by appointment by the President and confirmation by the Board of Directors for the unexpired term. Such appointee shall be from the Region in which the vacancy occurs.

(C) Vacancies not otherwise provided among the Officers or in the Board of Directors shall be filled by the Board of Directors until the next annual election.

SECTION 4. The Treasurer shall be the custodian of the funds and securities, and the collecting and disbursing officer of the National Association.

He shall deposit the funds and securities in such depositories and in such manner as the Board of Directors may designate and direct and shall be relieved of responsibility therefor while they are in the custody of such depository, subject, however, to any liability under his surety bond.

He shall provide a bond in a surety company qualified to do business in the State of Illinois or in the state of his principal depository in such amounts as shall be prescribed by the Board of Directors, covering the funds and securities held by him for the National Association and other funds and securities in his custody as Treasurer. The cost of the bond shall be paid by the National Association.

SECTION 5. The Secretary shall keep the records and seal of the National Association and performs such other duties as are customary to the office, including acting as Secretary for the Board of Directors and Executive Committee.

SECTION 6. The Board of Directors shall retain a General Counsel who shall perform the duties usual to such office.

SECTION 7. The Chief Executive Officer shall designate a member of the staff who, subject to the approval of the Executive Committee, shall serve as Comptroller and who shall be a Certified Public Accountant and conduct such functions as are usual to the business.

SECTION 8. There shall be a Chief Executive Officer who shall be appointed by the Board of Directors. The Chief Executive Officer shall be subject to the President and shall serve as the head of the staff, charged with its selection subject to the approval of the Executive Committee. The Chief

Executive Officer shall have supervision of the entire staff and shall perform such other duties as may be delegated to him by the Board of Directors, the Executive Committee or the President, and all other duties usual to such office.

The Chief Executive Officer shall provide a bond in a surety company qualified to do business in the State of Illinois or such other state as the headquarters of the National Association may be located, and of such amount as may be determined by the Board of Directors. The cost of such bond shall be paid by the National Association.

SECTION 9. The Chief Executive Officer shall serve as Secretary of the Association, ex officio.

SECTION 10. The Board of Directors may appoint an Administrative Secretary to perform the duties usual to that office and such other duties as may be assigned to him by the Board of Directors, the Executive Committee, the President, or the Chief Executive Officer.

SECTION 11. Any Administrative Secretary may be elected Assistant Secretary by the Board of Directors.

ARTICLE VIII

FINANCE AND PROFESSIONAL STANDARDS COMMITTEES - ANNUAL AUDIT - APPOINTMENT OF OTHER COMMITTEES

SECTION 1. There shall be a Finance Committee consisting of the Treasurer, who shall be the Chairman, one State Association Executive Officer and one Local Board Executive Officer appointed by the President to serve two year terms, the Vice-Chair of the Reserves Investment Subcommittee of the Finance Committee and the immediate Past Treasurer to serve one year terms, and twelve other members at least eight of whom were Directors when elected and no more than four of whom were not Directors when elected but have served previously as Directors. Members other than the Executive Officers, the Vice Chair of the Reserves Investment Subcommittee and the immediate Past Treasurer shall be elected to the Finance Committee for staggered terms of three years to commence on the day following the official closing of the National Convention at which they are elected, four being elected in each year to succeed those whose terms expire. Members so elected shall continue to serve until their successors are elected. At the meeting of the Board of Directors during the National Convention, the President-elect shall submit to the Board of Directors four or more nominations, not more than one of whom is not currently a Director but has served previously as a Director. The Board of Directors shall elect from such nominations sufficient members to fill existing vacancies. If any member of the Finance Committee fails to attend two consecutive meetings, his membership on the Finance Committee may terminate and his position may be deemed vacant at the discretion of the President. If a vacancy of an elected member occurs before the expiration of a term, the President shall submit to the Board of Directors for approval the nomination of a member to fill the unexpired term. Such member shall be a Director, or if not currently a Director, has previously served as a Director. If a vacancy of an Executive Officer member occurs before the expiration of the term, the President shall appoint an Executive Officer from a local board or state association to correspond with the vacant position to fill the unexpired term.

The Finance Committee shall prepare the annual budget for the ensuing fiscal year and submit it to the Executive Committee and Board of Directors for its approval or modification.

SECTION 2. The accounts of the National Association shall be audited annually as of the close of the fiscal year by a Certified Public Account designated by the Board of Directors. There shall be such interim and preaudit reviews and analyses of the accounts as may be directed by the Board of Directors or the Executive Committee.

SECTION 3. There shall be a Professional Standards Committee. It shall be the duty of this Committee to interpret the Code of Ethics, to consider and recommend appropriate action on inquiries of Member Boards and Board Members concerning enforcement thereof, and to recommend amendments thereto as it deems necessary or advisable.

SECTION 4.
(A) There shall be an Institute Advisory Committee, which shall consist of the President, President-Elect and Executive Vice President of each Institute, Society or Council and the President, President-Elect,

First Vice President and Chief Executive Officer of the National Association. A member of the National Association's Leadership Team appointed by the President shall serve as the Chairman and be an ex-officio member of the Committee during the term as Chairman. The Executive Vice Presidents and the Chief Executive Officer of the National Association shall serve without a vote.

(B) The Committee shall consider matters relating to the conduct of the Institutes, Societies and Councils, their relationship with one another and with the National Association and shall report to only the Executive Committee.

SECTION 5. There shall be a Distinguished Service Award Selection Committee consisting of nine members, the members of which shall have been recipients of the Distinguished Service Award. The Committee shall elect its own Chairman and Vice Chairman . No member shall serve for more than two consecutive three-year terms.

The Committee shall determine the recipients in accordance with such guidelines as the Committee shall recommend and the Executive Committee shall approve; and report its selection, if any, to the Board of Directors. The Award shall be presented at the Annual meeting of the Association. The Distinguished Service Award shall not be awarded posthumously, shall not be awarded to Past Presidents of the Association and shall not be awarded to more than two recipients in each elective year.

SECTION 6. There shall be a Leadership Team consisting of the President; President-Elect; First Vice President; Treasurer; Immediate Past President; Vice President and Liaison to Committees; Vice President and Liaison to Government Affairs; President-Elect Nominee(s); First Vice President Nominee(s); Treasurer Nominee(s); Vice President and Liaison to Committees Designee; Vice President and Liaison to Government Affairs Designee; and Chief Executive Officer.

Voting members of the Leadership Team shall be the President; President-Elect; First Vice President; Treasurer; Immediate Past President; Vice President and Liaison to Committees; and Vice President and Liaison to Government Affairs. In the event of a tie vote, the President shall determine the position to be taken with respect to the particular issue.

Except as to actions specifically stated in the Constitution or Bylaws or by law to require approval of or to be taken by the Board of Directors or Executive Committee, the Leadership Team shall have the authority to act on behalf of the Board of Directors and Executive Committee to make policy and operational decisions for the Association between meetings of the Executive Committee and Board of Directors. The Leadership Team shall report its actions, as appropriate, to the Executive Committee and Board of Directors.

The Leadership Team shall meet upon the call of the President or four of the voting members, stating the time and place of the meeting. A majority of the voting members of the Leadership Team, one of whom must be the President, shall constitute a quorum.

The Leadership Team may take any action which it could take at a meeting of the Leadership Team without a meeting if a consent in writing, setting forth the action so taken, is signed by all the voting members of the Leadership Team. Members of the Leadership Team may participate in any meeting through the use of a conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. Such participation in a meeting shall constitute presence in person at the meeting.

SECTION 7. There shall be such other committees as may be designated by the Board of Directors or the Executive Committee, the members of which shall be appointed by the President unless otherwise directed by the Board of Directors or the Executive Committee.

ARTICLE IX

NATIONAL CONVENTION - DELEGATES AND VOTING

SECTION 1. A National Convention shall be held annually at such time and place as may be fixed by the Board of Directors. The annual meeting of the members shall be held at the National Convention. Board Members and Individual Members present at any meeting of the National Association shall be delegates, entitled to participate fully in all discussions and deliberations.

SECTION 2. Voting shall be by Member Boards. The chief elected officer of a Member Board in good standing or his duly accredited alternate, who shall be a Board Member of the same Board, shall in viva voce cast the vote for his Board, and he shall be entitled to as many votes as his Board has REALTOR® or REALTOR-ASSOCIATE® Members who hold primary membership in the Member Board, all of whom must be in good standing according to the records of the National Association. In the event a viva voce vote is not unanimous, any delegate may request a recorded vote prior to the body's consideration of the next item of business, which request must be granted by the presiding officer. The recorded vote may be administered electronically, or by written ballot or by another process identified prior to the commencement of the meeting of the Delegate Body. Voting by proxy or division of the vote of a Member Board shall not be permitted.

SECTION 3. Written notice to certify delegates to the National Convention shall be given by the National Association to each Member Board at least 30 days before the convention. Member boards shall provide to the National Association written certification of the Member Board's delegate and/or alternate in such form, including electronic, as may be approved by the National Association no later than six business hours prior to the meeting of the Delegate Body.

SECTION 4. Wherever notice of meetings or of the subjects to be considered at meetings is required or authorized by this Constitution, publication of such notice in an official publication which is mailed to all members of the National Association within the required time limits, shall be deemed to be good and sufficient notice.

SECTION 5. Directors shall assume office on the day following the official closing of the Annual Convention and shall serve until their successors are selected and assume office.

SECTION 6. Chief elected officers of Member Boards or their accredited alternates present at the National Convention may make recommendations to the Board of Directors as to the general policies of the National Association and as to the actions to be taken upon specific questions.

SECTION 7. Chief elected officers of Member Boards or their accredited alternates from 100 Member Boards shall constitute a quorum.

SECTION 8. Chief elected officers of Member Boards or their accredited alternates shall meet at the National Convention and may meet at the Midyear Meeting when called to do so in accordance with Article XII, Section 2 of this Constitution.

SECTION 9. An Individual Member who is qualified to vote under Article III, Section 7 of this Constitution and is present at the National Convention, shall have the right to vote in person in any election in which chief elected officers of the Member Boards may vote.

ARTICLE X

ELECTIONS

SECTION 1. The annual election of officers shall be the first order of business at the Midyear meeting of the Board of Directors. Any election of the officers in which there is more than one candidate for the office shall be conducted by secret ballot. When an election is conducted by secret ballot, the vote count shall be reported to the Board of Directors. Thereafter the disposition of the ballots shall be in accordance with the policies established by the Board of Directors.

SECTION 2. There shall be a Nominating Committee consisting of:

(A) The Past President twice removed of the National Association or his most recent predecessor who is able and willing to serve;

(B) Two persons appointed by the Advisory Committee from among its members;

(C) One person appointed by the President of the National Association from each Region created pursuant to Article XIV, provided such person is not an announced candidate, has not served on the Nominating Committee during both of the two years preceding the year of appointment, and has served either as a Regional Vice President during the preceding five years or as a Director of the National Association during at least two of the preceding five years.

(D) The immediate Past President of the National Association shall serve as an ex officio member of the Committee.

(E) The Chairman shall be the Past President twice removed and if he is unable to serve, his most recent and available predecessor shall serve in his stead except that in no case shall a Past President serve as Chairman for two successive years.

(F) The President shall be advised by the Regions concerning those persons to be appointed by him to the Nominating Committee from the Region as well as the name of an alternate to serve on the Committee in the absence of the appointed representative. A member may not serve more than two consecutive one-year terms as the Region's representative on the Nominating Committee. The procedure by which the Regions shall advise the President shall be determined by the Region.

(G) Members of the Nominating Committee may not publicly endorse any candidate. A member of the Leadership Team may not publicly endorse any candidate, other than him or herself, during his or her term.

(H) The Nominating Committee shall meet at the Annual Convention or at a special meeting of the Nominating Committee called for the purpose of organizing itself, establishing its procedures, and initiating its deliberations. The Nominating Committee may hold, on its own motion, such meetings as it may deem necessary to complete its slate of nominees pursuant to the schedule set forth in this Article.

SECTION 3.

(A) There shall be a Candidate Audit Work Group comprised of the Chair and Immediate Past Chair of the Nominating Committee and three regional representatives from the Nominating Committee selected in random rotation.

(B) The Candidate Audit Group may hold such meetings as it deems necessary to complete its work pursuant to the schedule set forth in this Article.

(C)

1. The candidate's legal audit shall be conducted by, and the criminal background reports shall be obtained by, the General Counsel of the National Association who shall prepare an evaluation for submission to the Candidate Audit Work Group identifying issues from those reports based upon the guidelines established by the Board of Directors. Issues disclosed by the financial, legal and criminal background reports noted in the evaluation will first be reported to the candidate who will be given thirty (30) days to correct any inaccurate information before the evaluation is provided to the Candidate Audit Work Group.

2. The Candidate Audit Work Group shall review the application and the evaluation of the financial audit, legal audit and criminal background check for each candidate for President-elect, First Vice President, Treasurer and Regional Vice President. Any issues arising from this review that are deemed significant by the Candidate Audit Work Group will be reported to the Nominating Committee. If deemed appropriate by the Nominating Committee, those issues may also be disclosed to the Board of Directors if the member stands for election.

SECTION 4.

(A) All Persons who have received their state association's endorsement to be candidates for the National Association offices of President-Elect, First Vice President, and Treasurer shall file an application with the Nominating Committee within one year of receiving the endorsement. Applications must be filed between the1st day and the 15th day of April one year prior to the year in which the election for that office will take place. The application form must include the member's authorization to obtain financial, legal and criminal background reports for use in connection with the audit and election process. The Chairman of the Nominating Committee shall report to the Board of Directors at the midyear meeting of the National Association following the filing of these applications the names of all persons who have filed an application and the office for which they seek to be a candidate.

(B) Following the midyear meeting at which the names are reported to the Board of Directors by the Chairman of the Nominating Committee, the Nominating Committee shall review the qualifications of all candidates who have filed applications to determine their eligibility to serve as an officer of the National Association. This review shall include conducting interviews with each candidate, reviewing any issues raised by the Candidate Audit Work Group, personal interviews with the candidates by Past Presidents, if requested by the Past Presidents or the candidate, and the receipt of the candidate's home state endorsement and any other endorsements the candidate may elect to submit on behalf of him or herself from Regions, State and Local Associations and National Directors. Each endorsement received by the Nominating Committee must be signed and dated by an elected officer holding office in the year the Nominating Committee meets to review the qualifications of the endorsed candidate.

(C) In the event the Candidate Audit Work Group identifies to the Nominating Committee an issue in connection with any candidate for the office of Regional Vice President or if there is a contested election for Regional Vice President, the Nominating Committee may require an interview with that candidate or candidates for that Region.

(D) The Nominating Committee's review of the qualifications of all candidates for the offices of the National Association shall be completed prior to the next meeting of the Board of Directors at the annual meeting of the National Association. At that annual meeting of the National Association, the Nominating Committee shall nominate at least one nominee for each of the offices of President-Elect, First Vice President and Treasurer from among the declared candidates and a nominee for Regional Vice President for each of the Regions. Notice of the nominee slate and the list of qualified candidates for the offices of President-Elect, First Vice President and Treasurer shall be provided to the membership of the National Association prior to January 15th of the next year.

SECTION 5.

(A)

Names may be added to the slate of officers nominated by the Nominating Committee for the offices of President-Elect, First Vice President, Treasurer and Regional Vice President. These names may be placed in nomination by petition if the petition and required paper work providing the information for legal audit and authorizing the National Association to obtain the financial and criminal background reports for use in connection with the audit and election process is received at the headquarters of the National Association on or before February 28th of the year following nomination of the slate of officers by the Nominating Committee. Individuals nominated by petition need not have previously filed an application to be a candidate for office in the National Association.

(1) Petitions on behalf of candidates for the office of President-Elect, First Vice President, and Treasurer shall be signed by not less than one hundred twenty-five (125) of the Directors who were identified in the records of the National Association as holding their position as of the time the Nominating Committee nominated the slate of officers. Not more than one-fifth of the signatures shall be by Directors from the same State.

(2) Petitions on behalf of candidates for the office of Regional Vice President shall be signed by not less than twenty percent of the Directors of the Region which the Regional Vice President will represent of which Directors not more than one-half shall be from the same state.

(3) The financial audit, legal audit and criminal background check of members filing petitions shall be completed by the Candidate Audit Work Group prior to March 21st. The process followed by the Candidate Audit Work Group shall be as described in Section 3, except that the member shall have seven (7) days to correct any inaccurate information before the evaluation is disclosed to the Candidate Audit Work Group.

(B) The Board of Directors shall be advised of petitions properly filed for each office by notice sent to each Director either by mail or electronic communication on or before March 21st.

(C) No member may accept and no Region, State or Local Association, Board Member or real estate business owned in whole or in part by a Board Member may provide financial support and/or an official endorsement of any member to be a candidate for the office of National Association President-elect, First Vice President or Treasurer prior to the member's receipt of the endorsement of the member's home state association for that office. Upon receipt of his or her home state association's endorsement, the member shall be deemed to be an announced candidate and shall, within one year of receipt of the endorsement, file with the Nominating Committee his/her application to be a candidate for National Association office.

Note: The amendments to Article X adopted at the 2008 Annual Convention in Orlando, Florida shall be effective upon their adoption except for any affecting candidates filing in April, 2010 for the 2011 election of 2012 officers

ARTICLE XI

FISCAL AND ELECTIVE YEAR

SECTION 1. The fiscal year of the National Association shall be from January 1 to December 31, inclusive.

SECTION 2. The elective year of the National Association shall begin the day following the official closing of the Annual Convention and end the last day of the Annual Convention.

ARTICLE XII

MIDYEAR MEETING, AND SPECIAL MEETINGS

SECTION 1. The Board of Directors or the President, upon thirty days notice may issue a call for delegates of Member Boards and Individual Members who are qualified to vote individually to meet at the Midyear Meeting.

SECTION 2. Special meetings of the National Association shall be called by the Board of Directors or by the President upon petition by at least twenty percent of its Member Boards or upon petition signed by the number of Member Boards and Individual Members who are qualified to vote individually representing at least twenty percent of the total REALTOR® and REALTOR-ASSOCIATE® Members, and such Individual Members.

ARTICLE XIII

INSTITUTES, SOCIETIES AND COUNCILS

SECTION 1.

(A) For the purpose of affording those affiliated with Member Boards a greater opportunity for cooperation and discussion of administrative and business problems of the particular phases of the real estate business in which they are individually interested, the Board of Directors may establish Institutes, Societies or Councils of the National Association.

(B) No Institute, Society or Council shall be established or maintained which has less than one hundred Members.

SECTION 2.

(A) Institutes, Societies and Councils shall represent major fields of activity, or administrative and business problems in the real estate business. Institutes, Societies and Councils may, with the approval of the Board of Directors, adopt and amend corporate charters, adopt and amend Bylaws, elect governing bodies and officers, prescribe qualifications for membership, and establish and collect dues which shall be segregated in the books of account for their own use.

(B) Councils created for the consideration of administrative and business problems may elect a Chairman and appoint committees but may not levy dues or establish special membership requirements without the expressed approval of the Board of Directors of the National Association.

SECTION 3. Through 1997 Institutes, Societies and Councils shall meet during the National Convention at such times and places as may be allotted by the Convention Committee. Through 1998 should any Institute, Society or Council determine to meet at a time within seven days of the starting or ending dates of the Midyear Business Meetings of the NATIONAL ASSOCIATION OF REALTORS® and at a place within a radius of fifty miles of the city in which such meetings are held, such Institute, Society or Council shall meet with the National Association and on such dates and in such facilities as may be allotted by the Meeting/ Convention Committee. Effective in 1998 for the National Convention and in 1999 for the Midyear Meetings of the National Association, meetings of the Institutes, Societies and Councils may, subject to the policies of the Convention Meetings Committee of the National Association, be held either independent of or in conjunction with any such meeting of the National Association. The decision of each Institute, Society or Council to meet independently of the National Association, once reported to the National Association, shall not be alterable by the Institute, Society or Council. The Executive Vice President and President of each Institute, Society and Council or his designated representative shall attend the two annual business meetings of the National Association.

SECTION 4. Subject to the provisions of Article XX hereof, any action by the Institutes, Societies or Councils shall be subject to the approval of the Board of Directors. The Constitution, Articles of Incorporation and Bylaws of the Institutes, Societies and Councils shall specifically make appropriate provisions for such approval.

SECTION 5.

(A) Attendance at any or all meetings of the Institutes, Societies or Councils shall be open to all members of the National Association, provided that the privilege of such attendance at such meetings held in conjunction with the National Convention

shall be subject to the payment of the National Convention registration fee.

(B) If Institutes, Societies or Councils have established dues as provided in their Bylaws, only members of such Institutes, Societies or Councils shall be entitled to participate in their discussions, vote and receive without added cost their publications or other services.

SECTION 6. Members of the Institutes, Societies or Councils who hold a professional designation awarded by the Institute, Society or Council or who hold a class of membership that confers the right to hold office shall hold REALTOR®, REALTOR-ASSOCIATE® or Institute Affiliate Membership in Member Boards of the NATIONAL ASSOCIATION OF REALTORS®, provided, however, that persons who are currently employed in an executive, administrative or management capacity by a Member Board of the National Association, by a multiple listing service that is wholly-owned by one or more Member Boards, or by an Institute, Society or Council of the National Association, shall be eligible to earn, be awarded and maintain a professional designation offered by an Institute, Society or Council and provided further that persons engaged in the real estate business outside of the United States, its insular possessions and the Commonwealth of Puerto Rico shall not be obligated to maintain any form of membership in the NATIONAL ASSOCIATION OF REALTORS® as a precondition to membership in any Institute, Society or Council.

ARTICLE XIV

REGIONS

SECTION 1. The Board of Directors may create regions in the United States, and may conduct Regional meetings and conferences in such regions.

ARTICLE XV

STATE ASSOCIATIONS: MEMBERSHIP AGREEMENT

SECTION 1. The National Association may enter into a membership agreement with a state association which shall provide that all of the Member Boards in such state must be and continue to be, as a condition of continued membership in the National Association, Members of the state association. The Board of Directors shall consider such membership agreement only when and if requested by a state association, and a thirty-day written notice of such application shall be sent to all members of the Board of Directors preceding the meeting at which it will be considered. An application for such membership agreement may be granted by the National Association provided that the state association complies with the following standards and conditions:

(A) Such associations shall be organized with local boards as its constituent members, except that it may have individuals as Members in any area where there is no Member Board;

(B) Such association shall adopt the Code of Ethics of the National Association and agree to aid in its enforcement.

(C) Such association shall adopt as minimum requirements for election to membership of any local board or any individual the minimum requirements established by the National Association from time to time;

(D) Such association shall agree that after a specified date all of its Member Boards and Individual Members, as a condition of continued membership, shall hold membership in the National Association;

(E) The application of any such association for a membership agreement shall be endorsed by a number of Member Boards and Individual Members of the National Association in such state representing sixty-six and two-thirds percent of the REALTOR® Members and Individual Members therein;

(F) A state association having a membership agreement with the National Association may terminate such agreement by vote of a number of Member Boards and Individual Members of the National Association in such state representing sixty-six and two-thirds percent of the REALTOR® Members and Individual Members of such association.

SECTION 2. When the National Association shall have entered into a membership agreement with any state association complying with the provisions of this Article, any local board or individual holding primary membership in a local board within the territory of such association shall not be elected to membership in the National Association unless such board or individual shall be a member of such state

association, and Member Boards and Individual Members of the National Association within the territory of such state association shall, as a condition of continued membership in the National Association, maintain membership in such state association; provided, however, that the National Association shall reserve the right of review on the application of any local board refused membership in a state association and of retaining as a Member Board in the National Association any local board which resigns from a state association or which is expelled from such association for any cause other than the nonpayment of dues on a parity with other Member Boards in such state; and provided further, that any state association may, upon so notifying the National Association, also reserve the right of review on the application of any local board refused membership in the National Association and of retaining as a Member Board in such state association any local board which resigns from, or is expelled from, the National Association for any cause other than the nonpayment of dues to the National Association on a parity with other Member Boards.

ARTICLE XVI

GIFTS AND BEQUESTS

SECTION 1. The National Association may accept gifts and bequests which shall be administered by the Board of Directors and which shall constitute an endowment; the income derived from investment of such gifts and bequests shall be used to promote the objects of the National Association. The National Association also may accept gifts and bequests for specific purposes, provided such purposes shall have the approval of the Board of Directors, in which case such gifts or bequests shall be used only for the purposes and in the manner specified by the donor.

ARTICLE XVII

NATIONAL ASSOCIATION HEADQUARTERS

SECTION 1. The National Association shall maintain headquarters at Chicago, Illinois, or at such other place or places as may be designated from time to time by the Board of Directors.

SECTION 2. The legal headquarters of the National Association shall be maintained in Chicago, Illinois, the state of incorporation.

ARTICLE XVIII

BYLAWS

SECTION 1. Bylaws may be adopted or amended at any meeting by two-thirds of the Directors present at such meeting, provided that a quorum is present at such meeting, and provided that the substance of the proposed amendments shall have been submitted to the Member Boards at least 30 days in advance of their adoption.

ARTICLE XIX

AMENDMENTS

SECTION 1. This Constitution may be amended by two-thirds of the number of votes cast by the delegates at the National Convention, provided the proposed amendment shall first have been submitted in writing to and been reported upon by the Board of Directors, and provided further, that written notice of the substance of the proposed change has been sent to each Member Board and Individual Member who is qualified to vote individually at least 30 days prior to the meeting at which the amendment is to be considered. The notice may be sent by first-class mail, electronic communication, including e-mail, or any other means permitted by law that has been approved by the Board of Directors for sending such notices.

SECTION 2. The Code of Ethics may be amended by two-thirds of the number of votes cast by the delegates at the National Convention; provided the proposed amendment shall first have been submitted in writing and have been reported upon by the Board of Directors, and provided further, that written notice of the substance of the amendment has been sent to each Member Board and Individual Member who is qualified to vote individually at least 30 days prior to the National Convention at which the amendment is to be considered. The notice may be sent by first-class mail, electronic communication, including e-mail, or any other means permitted by law that has been approved by the Board of Directors for sending such notices.

ARTICLE XX

INSTITUTES, SOCIETIES AND COUNCILS, NATIONAL ASSOCIATION OF REALTORS® RIGHTS AND RESPONSIBILITIES

SECTION 1. The following rights and responsibilities are reserved to each of the Institutes, Societies and Councils respectively:

(A) The establishment of qualifications and the establishment and administration of procedures, for admission to candidacy and membership and the awarding of professional designations of the Institute, Society and Council to persons who are members of, or affiliated with, the National Association;

(B) The establishment of membership dues in the Institute, Society or Council and all other fees charged members and candidates for membership and others accredited, or seeking accreditation, by the Institute, Society or Council;

(C) The selection, supervision of and the determination of compensation and duties for all staff and other personnel of each Institute, Society or Council;

(D) The establishment of a Code of Ethics and Standards of Professional Practice for the Institute, Society or Council which are not inconsistent with the Code of Ethics of the National Association as from time to time amended; provided, however, that in order for its members to be eligible for Institute Affiliate Membership pursuant to Article III, such Institute, Society or Council must adopt and enforce the National Association's Code of Ethics or a code of ethics approved by the National Association that addresses the specialty area of that Institute, Society or Council, which code of ethics must apply to all persons who have been awarded a professional designation and those who hold classes of membership that confer the right to vote or hold office;

(E) The establishment and administration of appropriate procedures for the enforcement by each Institute, Society or Council of its Code of Ethics and Standards of Professional Practice;

(F) The determination of the qualification for, enrollment in, fees for, and the content, scheduling, administration, organization and operation of, all Institute, Society or Council education programs, curricula, courses, and seminars dealing with or relating to the phase of the real estate business with which the Institute, Society or Council is concerned;

(G) The preparation, publication, distribution and pricing of Institute, Society or Council educational material dealing with or relating to the phase of the real estate business and other matters with which the Institute, Society or Council is concerned, including the determination of content, viewpoint, and sources;

(H) The establishment, alteration and dissolution of local chapters of each Institute, Society or Council and the control over each such chapter's composition, powers and duties;

(I) Those other items, matters and activities as necessary to carry out those rights and responsibilities reserved to Institutes, Societies and Councils by this Article XX and which are not otherwise inconsistent with this Constitution.

SECTION 2. The National Association shall have the following rights and responsibilities:

(A) Primary responsibility to administer, coordinate, report on and deal with both legislative and executive branches of agencies of federal, state or local governments, including independent regulatory agencies and including, but not limited to, the duty to maintain a Washington office for the purpose of reporting to the membership of the National Association and the Institutes, Societies and Councils all matters concerning the activities or proposed activities of the executive and legislative branches and agencies of the Federal government that relate to real estate. The Committee structure shall provide the opportunity for the Institutes, Societies and Councils to have input into the decision-making process;

While the National Association has primary responsibility for the various matters enumerated above, it shall encourage the Institutes, Societies and Councils to assume a participatory role with respect to each of such activities.

The Institutes, Societies and Councils shall be permitted to engage in such activities with respect to issues in which the National Association is not involved or is inactive, so long as no positions are taken which conflict with positions of the National Association and provided further that the National Association shall have prior notice of all such

activities undertaken by any Institute, Society or Council.

In the event that an Institute, Society or Council adopts a policy on any legislative or regulatory matter that is in conflict with the policy of the National Association , both organizations shall make every reasonable attempt to resolve their differences. If, after all reasonable attempts to resolve such differences have been exhausted and the organizations are unable to resolve the conflict in policy positions, each organization shall be free to take whatever actions it deems necessary to advocate its policy.

(B) General responsibility to plan the National conventions and meetings including, but not limited to, the responsibility for coordinating the meeting schedules of the National Association and the Institutes, Societies and Councils so as to minimize scheduling conflicts;

(C) Responsibility to make available to the Institutes, Societies and Councils appropriate office space, accounting and computer services, mailing services and fringe benefits for staff so that such space, services and benefits will be of high quality at the lowest possible cost;

(D) Responsibility to assist in coordinating scheduling of Institutes, Societies and Councils educational courses and programs with the scheduling of educational courses and programs of other Institutes, Societies and Councils and the National Association so as to avoid whenever possible scheduling conflicts.

Although the National Association has the responsibility for the various matters enumerated above, this shall not be construed to restrict or prevent Institutes, Societies and Councils from assuming a secondary role with respect to each of such activities which is not inconsistent with the policy of the National Association.

SECTION 3. In the event that a question or controversy arises with respect to the proper interpretation of this Article XX, such question or controversy shall be referred to the Institute Advisory Committee. The Institute Advisory Committee shall make an investigation to determine the relevant facts and circumstances bearing upon the question or controversy, and if appropriate, shall conduct a hearing relating to the matter.

The decision of the Institute Advisory Committee with respect to any such questions or controversy relating to the proper interpretation of this Article XX shall be final unless, after notice as hereinafter specified, such decision is reversed by the affirmative vote of not less than two-thirds of the members of the Executive Committee of the National Association present at a regular or special meeting of such Executive Committee, the decision of the Executive Committee shall be final. The Executive Committee shall not take any action to modify or reverse any such decision of the Institute Advisory Committee unless written notice of the intention to consider such decision, together with the full report of the Institute Advisory Committee, shall be submitted to the members of the Executive Committee not less than twenty-four (24) hours prior to such action.

SECTION 4. The NATIONAL ASSOCIATION OF REALTORS® and each Institute, Society and Council affiliated with the National Association as of January 1, 1993 that is separately incorporated may terminate the affiliation established under Article XIII, Section 1(A) hereof by a two-thirds vote of the respective governing body, with any such disaffiliation to be effective eighteen months from the date of the vote to disaffiliate. Any affiliation established with an Institute, Society or Council subsequent to January 1 of 1993 may be terminated by a majority vote of the National Association's Board of Directors with such disaffiliation to take effect immediately unless otherwise specified by the Board of Directors.

BYLAWS

ARTICLE I

MEMBERSHIP

Section 1.
(A) Local boards shall be enrolled as Member Boards and individuals shall be enrolled as Individual Members when their written applications have been received and presented to the Board of Directors and when the Board of Directors shall find that the applicants have complied with the requirements of the Constitution and Bylaws. An applicant for REALTOR® membership pursuant to Article III, Section 1(C) 1.(b) shall be enrolled as a REALTOR® Member of the local Board designated in their application as their primary Board, and that Member Board shall accept the applicant as such when their written application has been received and presented to the National Association Board of Directors, the Board of Directors has found that the applicant has complied with the requirements of the Constitution and Bylaws, and the applicant has paid their initial dues, and any applicable initiation and processing fees to their primary Board.

(B) The application of any local board for membership in the National Association shall be in such form as may be prescribed by the Board of Directors and shall contain a statement to the effect that it has been approved by a majority of the REALTOR® Members of the applicant board. Effective January 1, 1974.

Section 2. No Member Board, nor any Institute, Society or Council, shall apply any arbitrary numerical or other inequitable limitation on its membership nor adopt any rule, regulation, practice or policy inconsistent with or contrary to any policy adopted by the Board of Directors.

Section 3. Unless qualified salesmen and independent contractors employed by or affiliated with a REALTOR® Member are eligible for REALTOR® membership in Member Boards, such salesmen and independent contractors shall be eligible for REALTOR-ASSOCIATE® membership in such Member Boards, and all Member Boards from and after January 1, 1974, shall make provision for such REALTOR-ASSOCIATE® membership.

Section 4. Resignations of local boards shall be considered and acted upon by the Board of Directors of the National Association; provided, however, that any local board tendering its resignation shall not be delinquent in its dues to the National Association, and provided further, that such resignation shall state the reasons therefore and shall verify that at least a majority of all its REALTOR® Members shall have voted in favor of such resignation.

ARTICLE II

ANNUAL DUES

Section 1.
(A) The annual dues of each Member Board (local Board) as defined in Article III, Section 1(B)(1) of the Constitution, shall be in an amount established annually by the Board of Directors at the Midyear Meeting times the sum of the number of REALTOR® and REALTOR-ASSOCIATE® members of the Board and the number of individuals who are licensed with such REALTOR® members of the Board and who are not themselves REALTOR®, REALTOR-ASSOCIATE® or Institute Affiliate members of the Board provided such individuals are not otherwise included in the computation of dues payable by another Member Board.

The annual dues of each Member Board (State Association) as defined in Article III, Section 1(B)(2) of the Constitution, shall be the amount established by the Board of Directors pursuant to Section 1(A) hereof times the sum of the number of REALTOR® and REALTOR-ASSOCIATE® members of the Board whose real estate office is located in a territory within the state which is outside the jurisdiction of any local Board and who are not primary members of any local board and the number of individuals who are licensed with such REALTOR® members of the Board and who are not themselves REALTOR®, REALTOR-ASSOCIATE® or Institute Affiliate members of the Board .

The annual dues of each Institute, Society or Council of the National Association shall be seventy-five dollars ($75.00) times the number of individuals who hold a professional designation awarded by that Institute, Society or Council or who hold a class of membership in the Institute, Society or Council which confers the right to hold office and who are not included in the calculation of dues payable by any Member Board or other Institute, Society or Council of the National Association.

(B) For the purpose of this section, a REALTOR® Member of a Member Board shall be held to be any Member who holds primary membership in the Member Board and who, as a sole proprietor, partner, or officer of a real estate firm or corporation or an individual in a position of management control on behalf of principals who are not physically present and engaged in the real estate business in connection with the firm's office, is actively engaged in real estate business as defined in Article III, Section 1 of the Constitution or who is a REALTOR® member of a Member Board pursuant to Article III, Section 1(C)1.(b) of the Constitution. A REALTOR-ASSOCIATE® Member of a Member Board shall be held to be any Member employed by or affiliated with a REALTOR® Member as a sales employee or independent contractor unless such Member is classified by the member Board as a REALTOR® Member in which case he shall be deemed a REALTOR® Member. An individual licensed in the state within which the board is located or within the state in which the real estate firm of the REALTOR® is located shall be deemed to be licensed with a REALTOR® if the license of the individual is held by a REALTOR® or by any broker who is licensed with the REALTOR®, provided that such licensee is not otherwise included in the computation of dues payable by a sole proprietor, partner, corporate officer or individual in a position of management control of the entity. Upon payment to the National Association of the dues required under Section 1(A) hereof, each REALTOR® and REALTOR-ASSOCIATE® Member in good standing of a Member Board shall be deemed respectively a REALTOR® or REALTOR-ASSOCIATE® Member in good standing of the National Association.

(C) A REALTOR® with a direct or indirect ownership interest in an entity engaged exclusively in soliciting and/or referring clients and customers to the REALTOR® for consideration on a substantially exclusive basis shall annually file with the REALTOR®'s primary board on a form approved by the National Association a list of the licensees affiliated with that entity and shall certify that all of the licensees affiliated with the entity are solely engaged in referring clients and customers and are not engaged in listing, selling, leasing, managing, counseling or appraising real property. The individuals disclosed on such form shall not be deemed to be licensed with the REALTOR® filing the form for purposes of this Section.

The Member Board dues shall be adjusted for any licensee included on a form submitted to a Board who during the same calendar year applies for REALTOR® or REALTOR-ASSOCIATE® membership in a Member Board as provided in Section 2(B) hereof, except that in the case of a new Member who held REALTOR® or REALTOR-ASSOCIATE® membership during the preceding calendar year the adjustment to Member Board dues shall not be prorated. The adjustment to Member Board dues for all new Members under this Section 1(C) shall be due and payable to the National Association by the last day of the month following the month active REALTOR® status is granted as evidenced in the National REALTOR® Database System.

Section 2.

(A) Each year each Member Board shall file with the National Association a list of the names of the REALTOR® and REALTOR-ASSOCIATE® Members of the Board and the numbers of individuals licensed with REALTOR® Members of the Board who are not themselves Board Members, which list and number shall be certified by the President and Secretary of the Board.

At the time such list is filed each Member Board shall pay dues for the current fiscal year based upon such list, which dues shall be adjusted each month to reflect any net increase in the number of individuals licensed with REALTOR® Members of the Board who are not themselves Board Members.

(B) Member Board dues shall also be adjusted for new Members enrolled by the Member Board who were not previously licensed with a REALTOR® Member of the Board during the current fiscal year. Except as provided for in Section 1(C) hereof, adjustments for new Members shall be prorated monthly and be due and payable to the National Association by the last day of the month following the month active REALTOR® status is granted as evidenced in the National REALTOR® Database System.

(C) In calculating the dues payable to the National Association by a Member Board, no member holding primary membership in another Member Board shall be considered, provided such member has notified the state association, and each local board to which he belongs of the identity of the Member Board where he holds primary membership.

(D) The policies and procedures for the reporting of members and payment of dues by the Institutes, Societies and Councils of the National Association

shall be established by the Board of Directors of the National Association.

Section 3.
(A) The annual dues payable by an Individual Member as defined in Article III, Section 1(D) of the Constitution shall be the amount established by the Board of Directors pursuant to Section 1(A) hereof, payable directly to the National Association.

(B) The annual dues payable by International Members as defined in Article III, Section 1(E) of the Constitution shall be established from time to time by the Board of Directors of the National Association with due consideration to the cost of the membership services provided.

Section 4. Each REALTOR® Member as defined by Article III, Section 1(C) 1.(b) of the Constitution shall pay dues to their primary Board annually in advance in accordance with the Bylaws of the Member's primary Board. Any REALTOR® Member as defined by Article III, Section 1(C) 1.(b) of the Constitution delinquent in payment of dues to the Member's primary Board shall be suspended or terminated automatically if their membership in the Member's primary Board is suspended or terminated by that Board for non-payment of dues, fees, fines or other financial obligations. A REALTOR® Member as defined by Article III, Section 1(C) 1.(b) of the Constitution terminated for non-payment of an amount owed to the Member's primary Board shall not be eligible for reinstatement to membership in the National Association unless such amount shall have been paid to the Board or otherwise satisfied.

Section 5. The dues of each Member Board, Individual Member, International Member and National Affiliate Member shall be paid annually in advance and shall be due to the National Association on January 1 of each year. If annual dues are not paid by April 1, the Association may assess such late charges and administrative fees as may be established by the Board of Directors. Any Member Board, Individual Member, International Member and National Affiliate Member delinquent in payment of dues by more than 90 days may be required to show cause as to why the Board of Directors, at its discretion, should not revoke the membership and/or charter of such member.

Any member failing to pay an assessment which has been duly approved by the Board of Directors within ninety (90) days of the due date established for payment of that assessment by the Board of Directors may be assessed such late charges and administrative fees as may be established by the Board of Directors. Any member delinquent in payment of an assessment by more than one hundred eighty (180) days from the due date established for payment of that assessment may be required to show cause as to why the Board of Directors, at its discretion, should not revoke the membership and/or charter of such member.

Section 6. Each person attending the National Convention shall pay such registration fee as shall be prescribed by the Board of Directors.

Section 7. Upon giving at least thirty (30) days notice in writing, and subject to the approval of the Board of Directors, any Institute, Society or Council, in accordance with its Bylaws, may:

(A) Increase its annual membership dues;

(B) Establish active, associate, and sustaining forms of membership.

Section 8.
(A) The payment of dues in an Institute, Society or Council shall entitle every member to such rights and privileges as may be provided in its Bylaws, subject to the approval of the Board of Directors of the National Association, except that the exercise of such rights and privileges at any session of an Institute, Society or Council held in conjunction with the National Convention shall be further subject to the payment of the convention registration fee and to conformance with the convention regulations of the National Association.

(B) Any member in good standing of an Institute, Society or Council who holds a professional designation awarded by an Institute, Society or Council affiliated with the National Association that addresses a specialty other than residential brokerage shall be entitled to Institute Affiliate membership in the National Association and in the Member Boards provided for in Section 11 of this Article.

Section 9. Notwithstanding anything in this Article to the contrary, the dues payable by a Member Board to the National Association shall be reduced by the amount established by the Board of Directors pursuant to Section 1(A) hereof, times the number of REALTOR® Emeriti, Past Presidents of the National Association and recipients of the Distinguished Service Award who are members of the Board.

Section 10. The Board of Directors may assess the members by class, provided that notice of the classes of membership to be assessed, the amount of the assessment for each of the classes to be assessed, the purpose of the assessment and when the assessment shall be due is submitted to the Member Boards at least 30 days in advance of its adoption. For assessments imposed on Member Boards, the amount to be paid by a Member Board shall be the amount of the assessment as stated in the notice times the sum of the number of REALTOR® and REALTOR-ASSOCIATE® members of that Member Board as certified by the President and Secretary of the Member Board pursuant to Section 2(A) hereof. Notwithstanding the foregoing, the amount to be paid by a Member Board shall be reduced by the amount of the assessment as stated in the notice times the number of REALTOR® Emeriti, Past Presidents of the National Association and recipients of the Distinguished Service Award who are members of the Board.

Section 11. From the dues paid by the Institutes, Societies and Councils of the National Association in accordance with Article II, Section 1 hereof, the National Association shall credit twenty-five dollars ($25.00) to the account of the Member Board (Local) for each individual included on the list provided by the Institute, Society or Council whose office address is within the assigned territorial jurisdiction of that Member Board, provided however, if the office location is also within the territorial jurisdiction of a Commercial Overlay Board, as provided for in Article III, Section 4 of the National Association's Constitution, the $25.00 amount will be credited to the Commercial Overlay Board, unless the Institute Affiliate Member directs that the dues be credited to the other board.

The National Association shall also credit twenty-five dollars ($25.00) to the account of the Member Board (State) for each individual included on the list provided by the Institute, Society or Council whose office address is within the assigned territorial jurisdiction of that Member Board (State).

ARTICLE III

TERRITORIAL JURISDICTION

Section 1. Except as provided in Section 2 of this Article, the territory of a Member Board shall be defined by the Board of Directors of the National Association, taking into consideration the ability of the Board to service its members and the public, to enforce the Code of Ethics, and to safeguard the registered marks of the National Association. All Member Boards shall have the same privileges and responsibilities set forth in this Article.

Section 2. Disputes concerning the jurisdiction and/or the name of a Member Board shall be determined by the Membership Policy and Board Jurisdiction Committee at a hearing conducted in accordance with the procedures approved by the Board of Directors. The decision of the hearing panel will be final except that the Board of Directors may require a new hearing before a different panel of the Committee if it determines the procedures failed to provide due process. Mergers, voluntary dissolutions, and uncontested changes of jurisdiction and/or changes of name of member boards may be administratively approved in accordance with the procedures approved by the Board of Directors.

Section 3. Jurisdiction of a Member Board is hereby defined to mean:

(A) The right and duty to control the use of the term REALTOR®, REALTORS®, and REALTOR-ASSOCIATE® jointly and in full cooperation with the NATIONAL ASSOCIATION OF REALTORS® subject to the conditions set forth in these Bylaws, including the duty to promptly report to the NATIONAL ASSOCIATION OF REALTORS® any unauthorized or improper use of such terms and to fully cooperate and coordinate with the NATIONAL ASSOCIATION OF REALTORS® in any and all attempts to halt or prevent any such unauthorized or improper use of these terms, and;

(B) The duty to enforce the Code of Ethics, and;

(C) The authority to accept as a REALTOR®, REALTOR-ASSOCIATE® or Institute Affiliate Member any person engaged in the real estate business, including brokerage, management, appraising, land development and building, and other related aspects of the real estate business who maintains an office within the state or within a state whose border is contiguous with that state and who complies with any licensure or other regulatory requirements applicable to his business activities within the state.

Section 4. If the territory of a Member Board has never been approved, the Board of Directors of the National Association shall, upon notice to such Member Board and an opportunity for hearing, define

its territory, and such action shall be binding upon the Member Board concerned.

Section 5. Any Member Board within whose territory a provision of this Article is violated by a member of another Member Board may complain of such violation to the Member Board of which the violator is a member, which Board thereupon shall take the necessary steps to enforce such provision. If it fails to do so, the complaining Board shall have the right to submit the matter to the National Association for appropriate action.

Section 6. Any Member Board which shall neglect or refuse to maintain and enforce the provisions of this Article or neglect or refuse to cooperate with the NATIONAL ASSOCIATION OF REALTOR® in the maintenance and enforcement of this Article with respect to its members may, after due notice and opportunity for hearing, be expelled by the Board of Directors from membership in the National Association.

ARTICLE IV

CODE OF ETHICS

Section 1. Each Member Board shall adopt the Code of Ethics of the National Association as a part of its governing regulations for violation of which disciplinary action may be taken.

Adoption of the Code of Ethics includes responsibility for providing applicant/new member Code of Ethics orientation and ongoing member ethics training that satisfies the learning objectives and minimum criteria established by the National Association from time to time.

Section 2. Any Member Board which shall neglect or refuse to maintain and enforce the Code of Ethics with respect to the business activities of its members may, after due notice and opportunity for hearing, be expelled by the Board of Directors from membership in the National Association. Enforcement of the Code of Ethics also requires Member Boards to share with the state real estate licensing authority final ethics decisions holding REALTORS® in violation of the Code of Ethics in instances where there is reason to believe the public trust may have been violated. The "public trust", as used in this context, refers to demonstrated misappropriation of client or customer funds or property, willful discrimination, or fraud resulting in substantial economic harm. Enforcement of the Code of Ethics also requires Member Boards to provide mediation and arbitration services to members and their clients so that the dispute resolution requirements of Article 17 of the Code of Ethics can be met.

Enforcement of the Code of Ethics also includes responsibility for ensuring that persons primarily responsible for administration of enforcement procedures have successfully completed training that meets the learning objectives and minimum criteria established by the National Association from time to time.

Enforcement of the Code of Ethics also prohibits Member Boards from knowingly granting REALTOR® or REALTOR-ASSOCIATE® membership to any applicant who has an unfulfilled sanction pending which was imposed by another Board or Association of REALTORS® for violation of the Code of Ethics.

ARTICLE V

USE OF THE TERMS REALTOR®, REALTORS® AND REALTOR-ASSOCIATE®

Section 1. Upon application of a Member Board, the Board of Directors may license such Board to use the term REALTOR® or REALTORS® as a part of its name under the following conditions:

(A) Such Board shall sign a written agreement with the Board of Directors of the National Association agreeing to eliminate the term REALTOR® or REALTORS® from its name immediately when and if it either shall cease to maintain or shall lose its membership in the National Association.

(B) The use of the term REALTOR® or REALTORS® in the name of such Board shall be in such manner as may be prescribed by the Board of Directors.

Section 2. Individual Members are hereby licensed to use the term REALTOR®, REALTORS® or REALTOR-ASSOCIATE® in connection with their business, provided the term is used in connection with a place of business which is not within the jurisdiction of a Member Board.

Section 3. REALTOR® Members are hereby licensed to use the term REALTOR®, REALTORS® or REALTOR-ASSOCIATE® in connection with their business, subject to the right of each Member Board to control, jointly and in full cooperation with the NATIONAL ASSOCIATION OF REALTORS® such use within its territory.

Section 4.
(A) A firm, partnership, corporation, or branch office whose principals actively engaged in the real estate business are REALTOR® members of a Member Board, except for the corporations of those REALTOR® members who hold membership pursuant to Article III, Section 1(C) 1.(b) of the Constitution, may use the term REALTOR® or REALTORS® in connection with, but not as a part of, its name thus: 'The _____ Real Estate Company, REALTORS®', but this privilege shall cease upon suspension or expulsion of any such principal from membership in the Board, and shall not revive unless or until he is readmitted to membership therein or his suspension expires or he severs his connection with the firm, partnership or corporation.

(B) The right to use the term REALTOR® or REALTORS® in connection with a firm, partnership, corporation or branch office shall be limited to office locations which a principal, partner, corporate officer or branch office manager of the firm, partnership or corporation holds REALTOR® membership. If a firm, partnership or corporation operates additional places of business which no principal, partner, corporate officer, or branch manager holds REALTOR® membership, the term REALTOR® or REALTORS® may not be used in any reference to those additional places of business.

Section 5. Each Member Board is hereby licensed to use the term REALTOR® or REALTORS® in the name of its headquarters building, in the title of its official publication, and of educational or civic meetings, services, or clinics sponsored by the Board, provided that the affiliation of the undertaking with the Member Board or the National Association is indicated, and that Board Members may participate therein.

Section 6. REALTOR® members are hereby licensed to use the terms REALTOR® or REALTORS® in connection with activities in support of specific candidates in specific elections to public office or nomination for election to public office, provided the definition of the term REALTOR® as a registered collective membership mark which identifies members of the NATIONAL ASSOCIATION OF REALTORS® and the identification of those conducting such activities as members of a member Board(s) is included on all letterhead and other written campaign literature, in all campaign media aids and on other materials unless not reasonably practical. Any such use must cease immediately after the election.

Section 7. Except as specifically otherwise provided in this Article, use of descriptive words or phrases in connection with the term REALTOR®, REALTORS® or REALTOR-ASSOCIATE® is expressly prohibited.

Section 8. Wherever the terms REALTOR®, REALTORS® or REALTOR-ASSOCIATE® are used in these Bylaws, they shall be understood to include the imprint of the emblem seal of the National Association.

Section 9. Any Member Board which shall neglect or refuse to maintain and enforce the provisions of this Article, or neglect or refuse to cooperate with the NATIONAL ASSOCIATION OF REALTORS® in the maintenance and enforcement of this Article with respect to its members may, after due notice and opportunity for hearing, be expelled by the Board of Directors from membership in the National Association.

Section 10.
(A) No Member Board shall sponsor, endorse, recognize, or award, directly or indirectly, any professional designation or certification that is confusingly similar to those available through the National Association, the Real Estate Buyer's Agent Council, or the Institutes, Societies, and Councils of the National Association.

(B) In the event a Member Board sponsors, endorses, recognizes or awards, directly or indirectly, any professional designation or certification that is not offered by the National Association, such Member Board shall clearly and affirmatively state in all course materials and related advertising and promotional materials that the professional designation or certification is not affiliated with or endorsed by the National Association of REALTORS®.

ARTICLE VI

COMMITTEES

Section 1. The President shall appoint such standing and special committees as shall be designated from time to time by the Board of Directors and such other special committees as he may deem necessary or appropriate.

Section 2. Unless otherwise provided in the NATIONAL ASSOCIATION OF REALTORS® Constitution or in these Bylaws, any action by a committee shall be subject to the approval of the Board of Directors.

ARTICLE VII

AMENDMENTS

Section 1. These Bylaws may be amended at any meeting by two-thirds of the Directors present at such meetings, provided that a quorum is present at such meeting, and provided the substance of the proposed amendments shall have been submitted to the Member Boards at least 30 days in advance of their adoption. The notice may be sent by first-class mail, electronic communication, including e-mail, or any other means permitted by law that has been approved by the Board of Directors for sending such notices.

ARTICLE VIII

RULES FOR MEETINGS

Section 1. Wherever notice of meetings or of the subjects to be considered at meetings is required or authorized by these Bylaws, publication of such notice in an official publication which is mailed to all members of the National Association within the required time limits, shall be deemed to be good and sufficient notice.

Section 2. The order of business of the National Association and its Institutes, Societies and Councils and committees, except where otherwise provided, shall be:

1. Call to Order
2. Taking of the Roll
3. Applications for Membership
4. Reading of Minutes
5. Reports of Officers
6. Reports of Committees.
7. Reports of Institutes, Societies and Councils
8. Unfinished Business
9. New Business
10. Appointment of Committees
11. Election of Officers

Section 3.
(A) The substance of any resolution to be acted upon at any National Convention or other meeting of delegates shall be submitted in writing to the Member Boards at least 45 days in advance of the convention or meeting.

(B) This provision may be waived by the consent of two-thirds of the delegates present and entitled to vote at such convention or meeting.

(C) This provision shall not apply to any resolution adopted by the affirmative vote of at least two-thirds of the Directors present at any regularly constituted meeting of the Board of Directors.

Section 4. All resolutions and motions must be made in writing, if the presiding officer so requests, or if the request is by majority vote of the delegates present at any convention or meeting.

Section 5. Robert's Rule of Order, Latest Edition, shall be recognized as the authority governing the meetings of the National Association and its Institutes, Societies and Councils, and committees, except where otherwise provided, and when not in conflict with its Constitution and Bylaws.

ARTICLE IX

DEFENSE AND INDEMNIFICATION OF OFFICERS AND DIRECTORS

Section 1. In the event of suits or claims in which one or more current or past officers or directors or employees of the Association are named as a result of their status as such or decisions or actions taken in good faith and reasonably understood to be within the scope of their authority or employment during their term as such, the National Association shall, directly or through insurance secured for the benefit of such officers and directors and employees, secure counsel to act on behalf of and provide a defense for such officers, directors and employees; pay reasonable defense expenses incurred in advance of final

disposition of such case; and indemnify such officers, directors and employees with respect to any liability assessed or incurred as a result of any such claim, suit or action.

Section 2. The above stated defense and indemnification of officers, directors and employees shall extend to those individuals when serving at the request of the Association as a director, officer or employee of another entity, but only after indemnification and insurance coverage from such other entity has been exhausted.

ARTICLE X

REALTORS® INFORMATION NETWORK

Section 1. The President or, in the event the President is unable or unwilling to act, the President-Elect, shall have the authority and responsibility for voting the shares of stock of the REALTORS® Information Network owned or controlled by the National Association. The President or President-Elect shall always vote those shares in accordance with the instructions of the Board of Directors or, where authorized elsewhere in this Article, the Leadership Team.

Section 2. Unless a matter to be considered by the stockholder of the REALTORS® Information Network will be voted upon prior to the next meeting of the Board of Directors of the National Association, all such matters shall be submitted to the Board of Directors of the National Association which shall determine how the President or President-Elect shall vote the shares owned or controlled by the National Association. If the vote of the shareholder is without instruction from the Board of Directors, any matter to be considered by the shareholder shall be submitted to the Leadership Team, which shall determine how the President or President-Elect shall vote the shares owned or controlled by the National Association, provided however, that any shareholder vote regarding items set forth in Article II, Section 6 of the bylaws of the REALTORS® Information Network, Inc. must be submitted to the National Association's Board of Directors for a determination of how shares owned or controlled by the National Association shall be voted.

Section 3. Upon receipt by the Secretary of the National Association of either a written statement signed by the President of the National Association or a petition signed by any four Regional Vice Presidents of the National Association, which statement or petition names a Director of the REALTORS® Information Network and requests the removal of that Director from the Board of Directors of the REALTORS® Information Network, the Secretary shall forward the statement or petition to the Executive Committee to make a recommendation to the Board of Directors which shall vote on whether to remove the Director. If the Executive Committee and Board of Directors are not scheduled to meet within thirty days of receipt of the statement or petition, the Secretary shall forward the statement or petition to the Leadership Team for a vote on whether to remove the Director.

In the event the Board of Directors or, where appropriate, the Leadership Team, votes to remove the Director from the Board of Directors of the REALTORS® Information Network, the President or, if the President is unable or unwilling to act, the President-Elect, shall act forthwith to remove that Director, including, if necessary, calling a special meeting of the shareholder and voting the shares owned or controlled by the National Association in accordance with the instructions of the Board of Directors or Leadership Team.

ARTICLE XI

MISCONDUCT

Any member or appointed officer of the Association may be reprimanded or removed from a committee or an appointed leadership position for sexual harassment of an Association member or employee. The discipline to be imposed shall be determined by the President, President-Elect, First Vice President, Treasurer and one member of the Board of Directors selected by the President after an investigation in accordance with established procedures and after consultation with legal counsel.

Any elected officer of the Association may be reprimanded or removed from office for sexual harassment of an Association member or employee. The discipline to be imposed shall be determined by five members of the Executive Committee selected by the highest ranking officer not named in the complaint after an investigation in accordance with established procedures and after consultation with legal counsel. If the recommendation is to remove the elected officer from office, the officer will be given the opportunity to resign. If he or she refuses to resign, the report from the investigatory team will be provided to the Executive Committee for final determination. The Executive Committee may remove the officer from office by a two-thirds vote.

ARTICLE XII

BUILDING FUND

Section 1. The Treasurer shall maintain in accordance with Generally Accepted Accounting Principles a separate record among the assets of the National Association of all real property owned by the National Association which is, has been or is planned to be used for the offices of the National Association.

Section 2. In the event any asset of the type referred to in Section 1 hereof is sold by the National Association, the proceeds of that sale, less the direct expenses of the sale, shall be held in a Building Fund created by the Treasurer of the National Association.

Section 3. Funds held in the Building Fund shall be deposited in such depositories and in such manner as the Board of Directors may designate and direct or invested in such manner as is consistent with the investment policies for the Building Fund approved by the Board of Directors of the National Association. All or part of the funds held in the Building Fund may be commingled with other funds of the National Association for purposes of their deposit or investment. All interest earned and any gain or loss recognized on the principal of the Building Fund shall be added to or subtracted from the principal of the Building Fund.

Section 4. Expenditures from the Building Fund shall require the approval of the Board of Directors. Expenditures for the purpose of acquiring ownership of real property to be used for the offices of the National Association shall require approval by a majority vote of the Board of Directors. Expenditures for any other purpose or transfers to other of the National Association's designated funds shall require approval by a two-thirds vote of the Board of Directors.

Official Interpretations

of

ARTICLE 1, SECTION 2
BYLAWS
of the

* NATIONAL ASSOCIATION OF REALTORS®

ARTICLE 1, SECTION 2

of the

National Association Bylaws

"No Member Board, nor any Institute, Society or Council, shall apply any arbitrary numerical or other inequitable limitation on its membership nor adopt any rule, regulation, practice or policy inconsistent with or contrary to any policy adopted by the Board of Directors."

(Revised November 13, 1973)

IN GENERAL:

In licensing to Member Boards the right and duty to control the use of terms "REALTOR®" and "REALTOR-ASSOCIATE®" and to determine those qualified to use the terms, the NATIONAL ASSOCIATION OF REALTORS® contemplates that local Boards of REALTORS® are best able to investigate and determine the qualifications of applicants as to their ability, responsibility, willingness to abide by the Code of Ethics, integrity and general reputation. It does not contemplate that Member Boards will impose arbitrary regulations contrary to practices governing professional or trade organizations or requiring members to conduct their business according to methods unrelated to ethical conduct.

To protect itself against arbitrary action by a Member Board which could be held violative of the law or of public policy, the National Association Bylaws for many years have included Section 2 of Article 1, which expressed long-standing policy. It is one of several requirements incorporated in its Bylaws that the National Association places upon a Board which desires to obtain or retain membership in the National Association. This is the only section, however, which is stated in general terms and, therefore, is subject to interpretation. An interpretation, to be official, must be made by the Board of Directors of the NATIONAL ASSOCIATION OF REALTORS®.

The four bases upon which a Board either may be refused membership in the NATIONAL ASSOCIATION OF REALTORS® or its membership in the National Association be terminated are:

(1) failure to maintain and enforce the Code of Ethics with respect to the business activities of its members;

(2) failure to maintain and enforce the requirements of the Bylaws relating to the use of the term "REALTOR®;"

(3) applying any arbitrary numerical or other inequitable limitation on its membership; and

(4) being otherwise in violation of the Constitution and Bylaws of the National Association.

In the event complaint is received by the NATIONAL ASSOCIATION OF REALTORS® that a Member Board is failing in its obligations to the National Association, the Member Board will be required to show cause why its charter from the National Association should not be revoked and its membership terminated.

INTERPRETATION NO. 1

(Adopted November 15, 1960)

"A requirement to participate in a Multiple Listing Service in order to gain and maintain REALTOR® membership is an inequitable limitation on its membership."

When a Multiple Listing Service is available, is well operated and properly organized, it is the duty of the REALTOR® to consider thoroughly whether he can serve the best interests of his clients by participating in it. The decision, however, must be his own. As a REALTOR®, it is possible for him to conduct business in an ethical and efficient manner without participating in a Multiple Listing Service. Therefore, his participation must not be a requirement of REALTOR® membership.

INTERPRETATION NO. 2

(Adopted January 24, 1961)

"An initiation fee in excess of three times the amount of the annual rates of dues is an inequitable limitation on its membership."

Member Boards must not place unreasonable burdens on applicants for membership. The requirements for membership must be reasonable and non-discriminatory.

The initiation fee, if any, charged by a Board must not constitute unreasonable barrier to membership of a person otherwise qualified. Nor should a Board seek to finance its activities and operations from initiation fees.

The National Association deems any initiation fee in excess of three times the amount of the annual rates of dues, including state and national, to be unreasonable and therefore inequitable.

Since under Interpretation No. 1, participation in a Board Multiple Listing Service is not mandatory, the Board initiation fee, if any must be separate from any participation fee which may be charged for the Multiple Listing Service.

INTERPRETATION NO. 3

(Adopted January 24, 1961)
(Revised May 8, 1973)
(Deleted November, 12, 1990)

INTERPRETATION NO. 4

(Adopted January 24, 1961)
(Revised May 3, 1973)
(Deleted May 19, 1997)

INTERPRETATION NO. 5

(Adopted January 24, 1961)
(Revised May 19, 1997)

"Stated qualifications for membership should be limited to those affecting licensure, professional conduct, portability of member records, and bankruptcy."

The criteria by which applicants will be considered should be written, reasonable and non-discriminatory so that there is a clear basis for evaluation. There are two sets of Membership Qualification Criteria of the National Association, one for applicants for REALTOR® and REALTOR-ASSOCIATE® membership who are other than sole proprietors, partners, corporate officers or branch office managers in a real estate firm and the other for applicants for REALTOR® membership who are sole proprietors, partners, corporate officers or branch office managers in a real estate firm.

They are the most rigorous qualifications which may be required by a Board of REALTORS® in the consideration of applicants for REALTOR® and REALTOR-ASSOCIATE® Membership.

The Board's Membership Committee (or other duly constituted group) may be properly charged with the responsibility of reviewing applicants for membership, determining the qualification, interviewing them personally, and requiring that they record their qualifications in a written form of "Application for Membership" (many Boards publish and use their own forms and the National Association has such a suggested form available to Boards).

Each applicant's qualifications must be considered under the established criteria consistently applied.

A Membership Committee should retain a record of applicants for membership and in the event that rejection of an applicant is recommended, a record of the basis of denial should be made and reviewed with Board legal counsel.

INTERPRETATION NO. 6

(Adopted January 24, 1961)

"Any regulation restricting or limiting the practice of a REALTOR® in the conduct of his business, unless it concerns ethical practice, is an inequitable limitation on its membership."

This Interpretation establishes a rather general guide to the type of rules which a board may adopt, i.e., in furtherance and support of the Code of Ethics, but guards against the type of rules which unreasonably restrict the member in the conduct of his business on a basis other than related to the Code of Ethics.

The intent of this Interpretation is to avoid the necessity of the Board of Directors passing upon

innumerable details about which Boards constantly inquire. The administrative staff is under instruction to advise a Member Board, upon inquiry, as to whether a practice or proposed rule appears to be inconsistent with, or in violation of, the Bylaw against inequitable rules. If the Member Board then wishes to request an official Interpretation by the Board of Directors, it may do so.

Any member also is entitled to an Interpretation upon request. However, as a matter of policy, the National Association prefers that inquiries come from Member Boards. It cannot, however, deny any member the right to request an Interpretation.

INTERPRETATION NO. 7

(Adopted January 24, 1961)
(Revised January 30, 1984)

"Restrictions which prohibit REALTOR® membership to a person who has his principal place of business in the jurisdiction of another Board of which he is a REALTOR® Member, merely because he has only a branch office in the jurisdiction of the Board to which he applied, is an inequitable limitation on its membership."

If an individual maintains an office within the jurisdiction of the Board, whether that office be a principal office or a branch office, that fact qualifies the principal broker or the branch office manager as an applicant for membership. Whether as an applicant the principal broker or the branch office manager meets the established requirements of the Board is a matter for decision by the Board.

It is intended that in those instances in which a sole proprietor, partner, or corporate officer is not physically present and actively engaged in the real estate profession in connection with the firm's branch office located within the jurisdiction of the Board, and the principal broker of the firm chooses not to hold REALTOR® Membership in the Board, the individual exercising management control shall stand in the shoes of the owner(s) and shall be the 'designated' REALTOR® to whom the Board shall look for compliance with all duties and obligations of REALTOR® Membership.

In those instances in which the firm's principal office is located within the jurisdiction of the Board, and the firm maintains one or more branch offices also within the jurisdiction of the Board, the Board may require that the supervising partner (i.e., the 'chief principal' of the firm whether a sole proprietor, partner, or corporate officer) be the 'designated' REALTOR® for all of the firm's offices within the jurisdiction of the Board.

INTERPRETATION NO. 8

(Adopted January 24, 1961)
(Revised April 24, 1990)
(Revised November 12, 1990)

"It is not an inequitable limitation on membership for a Board of REALTORS® to require that applicants for REALTOR® Membership who are principals in a real estate firm must maintain a real estate broker's or salesperson's license or must be licensed or certified by an appropriate state regulatory agency to engage in the appraisal of real property."

The National Association recognizes the right of the Board to determine who is engaged in the real estate business and thereby eligible for membership.

It should be noted that Boards which limit REALTOR® Membership to principals in a real estate firm must make REALTOR-ASSOCIATE® Membership available to otherwise qualified applicants affiliated with the REALTOR®'s firm.

INTERPRETATION NO. 9

(Adopted January 24, 1961)
(Revised May 8, 1973)

"Requirement of a 'Waiting Period' before being considered for REALTOR® membership is not an inequitable limitation on its membership if related to the period of time necessary to process the application, not to exceed six months."

It is consistent with assurance of ethical business practice for a Board of REALTORS® to require that an applicant for membership submit an application detailing past history. The National Association, as a matter of policy, urges thorough investigation into the background of applicants for membership. This affords the Board an opportunity to investigate the individual's business conduct and record.

An applicant is entitled to prompt consideration of his application and final disposition of such application must be made within six months.

INTERPRETATION NO. 10

(Adopted May 9, 1961)

"A Board rule purporting to require a REALTOR® who holds an exclusive listing to give blanket consent to either sub-agents or cooperating brokers to negotiate directly with the owner, rather than through him, obstructs observance of Article 3, and thereby is an inequitable limitation on its membership."

This Interpretation affirms the basic agency relationship between the listing broker and his principal as defined in the listing contract. A Board or MLS rule may not properly interfere with or supersede the relationship established by the terms of the agreement between the broker and his principal.

The cooperating broker as a sub-agent of the listing broker enjoys only such rights to show or sell the listing as are granted to him by the listing broker who is ultimately responsible to his principal.

INTERPRETATION NO. 11

(Adopted May 9, 1961)

"A rule of a Member Board prohibiting the acceptance of open listings by members is an inequitable limitation on its membership."

Although the Preamble of the Code of Ethics places upon the REALTOR® the aspirational ideal that he urge the exclusive listing of property, it does not provide that a non-exclusive listing should not be accepted.

The REALTOR® must be free to enter into any form of listing contract mutually agreeable to the REALTOR® and the client.

INTERPRETATION NO. 12

(Adopted May 9, 1961)

"A rule of practice prohibiting members from keeping their offices open on Sunday is a restriction on a member's business practice unrelated to the Code of Ethics and, therefore, is an inequitable limitation on its membership."

While this Interpretation refers to a rule relating to Sunday closings, it is clear that any Board rule limiting office hours or days of work would be an unreasonable restraints and hence an inequitable limitation on membership.

INTERPRETATION NO. 13

(Adopted May 9, 1961)

"A Board may adopt a rule requiring that every member maintain a trust account for funds of clients. But a rule requiring annual audit of such accounts, the filing with the Board copies of such reports, and providing for surprise audit visits to inspect records of such accounts is an inequitable limitation on its membership."

The maintenance of a trust account for funds of clients is a requirement of Article 8 of the Code of Ethics as well as the requirement of many state license laws.

However, the establishment and enforcement of rules providing for audit, inspection, etc. are not properly the function of a voluntary organization such as a Member Board.

INTERPRETATION NO. 14

(Adopted May 9, 1961)
(Revised January 26, 1971)

"A Member Board rule or practice which requires Members to adhere to a schedule of fees or commissions, or which authorizes or includes the preparation or publication of a recommended schedule of fees or commissions, is contrary to the Code of Ethics and to the policy of the NATIONAL ASSOCIATION OF REALTORS® and is an inequitable limitation on its membership."

INTERPRETATION NO. 15

(Adopted May 9, 1961)

"A Board rule prohibiting REALTORS® or their salesmen from accepting elective or appointive public office, or requiring their resignation if they accept such office, is an inequitable limitation on its membership."

INTERPRETATION NO. 16

(Adopted May 9, 1961)

"A Board rule prohibiting employment of married women as salespersons is an inequitable limitation on its membership."

This Interpretation is a specific application of the general policy of Interpretation No. 20.

INTERPRETATION NO. 17

(Adopted November 16, 1961)

"A Board rule imposing an age limit upon applicants for membership is an inequitable limitation on its membership."

Age is not a reasonable criterion for membership.

INTERPRETATION NO. 18

(Adopted November 16, 1961)
(Revised November 7, 1994)

"A Board rule which seeks to attain the aspirational objectives of the Code of Ethics by requiring, as a condition of Board membership, completion of an objective and non-discriminatory Indoctrination Course with a stated passing grade in an examination thereon is not an inequitable limitation on its membership."

A board rule requiring the applicants for REALTOR® or REALTOR-ASSOCIATE® membership satisfactorily complete an objective and non-discriminatory indoctrination course covering the Constitution and Bylaws of the local board, state association and National Association, the Code of Ethics of the National Association, and anti-trust laws, fair housing laws, and agency laws is not an inequitable limitation.

INTERPRETATION NO. 19

(Adopted November 12, 1962)
(Revised May 8, 1973)

"A Board rule placing upon REALTORS® the responsibility of requiring their salespersons to hold REALTOR-ASSOCIATE® membership in the Board is an inequitable limitation on its members, and a Board rule requiring that a member obtain Board approval for the employment of or contracting with any employee or salesman is also an inequitable limitation on its membership."

A salesman cannot be required by the Board of REALTORS® to become a REALTOR-ASSOCIATE®. REALTOR-ASSOCIATE® membership is **not** mandatory. A REALTOR® in the exercise of his individual discretion may, of course, desire to employ or affiliate himself with salespersons who are willing to become REALTOR-ASSOCIATE®s. This, however, is a matter between the REALTOR® and the salesperson and is not a requirement.

A real estate salesperson shall be eligible to apply for REALTOR-ASSOCIATE® membership immediately upon his employment by or affiliation as an independent contractor with a REALTOR®.

The second clause of this Interpretation is closely related to Interpretation No. 20 to the extent that both Interpretations are intended to make inequitable any rule which would interfere with the REALTOR®'s right to employ or affiliate himself with any salesperson.

INTERPRETATION NO. 20

(Adopted November 12, 1962)
(Revised May 9, 1973)

"A Board rule which restricts its REALTOR® membership in their employment of or contractual relationship with any employee or salesperson is an inequitable limitation on its membership."

The REALTOR® has the right to employ or associate himself with those salespersons of his choice and the Board must not restrict this right.

The REALTOR® Member is responsible to the Board of REALTORS® for the action of employees or associates who are not themselves REALTOR-ASSOCIATE® Members of the Board of REALTORS®.

INTERPRETATION NO. 21

(Adopted November 12, 1962)

"A Board rule regulating the number of married women that may be employed is an inequitable limitation and comes within Interpretation No. 16."

INTERPRETATION NO. 22

(Adopted November 12, 1962)

"A Board rule that requires attendance at a reasonable number of meetings of the Board is not an inequitable limitation on its membership."

Attendance at meetings of the Board -with implied participation in its activities - is consistent with the requirements of the Code of Ethics.

Consideration should be given to extending credit for attendance at related functions such as State and National Association meetings and Institute, Society and Council meetings.

INTERPRETATION NO. 23

(Adopted November 12, 1962)

"A Board rule that requires that members attain a stated earnings level, or complete a stated number of transactions, or both, is an inequitable limitation on its membership."

INTERPRETATION NO. 24

(Adopted February 2, 1965)

"A Board policy or rule deferring for a specified time, or indefinitely, or to a specified date, any consideration of all applications for membership is an inequitable limitation on its membership."

This Interpretation requires Boards of REALTORS® to accept and promptly process applications from individuals desiring membership.

INTERPRETATION NO. 25

(Adopted May 11, 1965)

"A Board rule which prevents the participation of a REALTOR® Member, on equal terms with other REALTOR® Members, in a Multiple Listing Service sponsored, organized or sanctioned by the Board, and which is available to REALTOR® Members throughout the Board's jurisdiction, is an inequitable limitation on its membership."

A Board rule which makes services available to some REALTOR® Members, but not to other REALTOR® Members, when such services are available generally throughout the Board's jurisdiction, is an inequitable limitation upon the membership.

INTERPRETATION NO. 26

(Adopted May 10, 1966)
(Revised November 16, 1977)

"A Board rule prohibiting the posting by members of "for sale" or similar signs on property for which the member is agent is an inequitable limitation on its membership."

The right to display "for sale" or other similar signs reasonably designed to inform the public is protected by the First Amendment to the United States Constitution. Thus, any rule prohibiting the posting of such signs would be an unconstitutional infringement of the freedom of speech of the REALTOR® and his client. Similarly, a Board owned or operated Multiple Listing Service may not endorse any programs by municipalities, civic groups or civil rights organizations to ban or curtail signs, even if such programs are "voluntary," because of the "chilling effect" such endorsements might have on the exercise of First Amendment rights.

INTERPRETATION NO. 27

(Adopted January 26, 1971)
[**Deleted February 7, 1994)**

INTERPRETATION NO. 28

(Adopted May 9, 1972)
(Revised May 19, 1997)

"A Board rule denying a REALTOR® Member, in good standing, full voting rights is an inequitable limitation on its members."

The Preamble of the Code of Ethics establishes aspirational objectives which REALTORS® are encouraged to follow in furtherance and support of the objective Articles in the Code of Ethics to advance the real estate profession. With the obligation to abide by the Articles of the Code of Ethics there is a corresponding right to participate in the formulation of Board policy.

The right to vote contemplated by this Interpretation shall not be deemed denied to a broker otherwise eligible for REALTOR® membership if: (1) such broker voluntarily elects a REALTOR® membership classification authorized by the Board having limited or no voting rights; and (2) at least one principal, partner, officer, or trustee of the firm, partnership, corporation or trust with which such broker is affiliated or by which he is employed is a REALTOR® Member having full voting rights.

Further, this right to vote extends to all phases of Board operation wherein REALTOR® Members are granted the right to vote including, but not limited to, voting as participants in a Multiple Listing Service. In the event that participation in the Multiple Listing Service is by firms, the firm shall be entitled to one vote. Conversely, if participation is by individuals, a firm with three REALTOR® Members, paying three participation fees, would be entitled to three votes.

INTERPRETATION NO. 29

(Adopted May 8, 1973)

"Application and entrance fees for participation in a Multiple Listing Service, owned by, operated by or affiliated with a Board of REALTORS®, in excess of the approximate cost, including the accumulation and maintenance of reasonable reserves, of developing, maintaining, or improving the organization as a going concern, is an inequitable limitation on the membership.

All services of a Board of REALTORS®, including Multiple Listing Service, should be available to all REALTOR® Members without restrictive entrance and application fees. Such fees should be related to the approximate costs of bringing the Service to the Member and must not be computed on the basis of the number of listings of a Multiple Listing Service or on the basis of a *pro rata* share of its assets.

INTERPRETATION NO. 30

(Adopted May 8, 1973)

"Enforcement of the Code of Ethics by any group, within or without the Board of REALTORS®, other than the Professional Standards Committee and the Board of Directors of the Board of REALTORS® is an inequitable limitation on its members."

Member Boards are required by Article IV of the Bylaws of the National Association to enforce membership compliance with the Code of Ethics. This obligation is properly fulfilled by the Professional Standards Committee and the Board of Directors of the Board. Delegation of this function by the Board to any other body, such as a Multiple Listing Committee, is not appropriate.

INTERPRETATION NO. 31

(Adopted May 8, 1973)
(Revised January 31, 1977)

"A Board rule or a rule of a Multiple Listing Service owned by, operated by or affiliated with a Board, which establishes, limits or restricts the REALTOR® in his relations with a potential purchaser, affecting recognition periods or purporting to predetermine entitlement to any award in arbitration, is an inequitable limitation on its membership."

In essence, this is a specific Interpretation of the general rule established in Interpretation No. 6 that a Board may not have a rule which restricts or limits the REALTOR® in the conduct of his business unless it concerns ethical practice. Thus, a rule of a Board or Multiple Listing Service which would determine a protection period in reference to a prospective purchaser is an inequitable limitation. Further, the Board or its MLS may not establish a rule or regulation which purports to predetermine entitlement to any awards in a real estate transaction. If controversy arises as to entitlement to any awards, it shall be determined by a hearing in arbitration on the merits of all ascertainable facts in the context of the specific case of controversy.

INTERPRETATION NO. 32

(Adopted May 8, 1973)

"The inclusion in the dues payable by Board Members of costs of services or activities of the Board which properly should be optional is an inequitable limitation on its membership."

The dues payable by Board Members should represent the allocable costs of the services and facilities which are available to and benefit the members generally, either directly or indirectly. It should not include the costs of those services or facilities which can be identified as optional. Thus, for example, the cost of participating in the Board's MLS should not be included as part of Board dues since whether a member determines to participate in such an activity will depend upon the member's particular method or type of business. The reasonable cost of meals at general membership meetings held pursuant to the Board's bylaws may be included in Board dues since such meetings are necessary to the operations of the Board as a whole provided that no more than 35% of the local allocation of the Board's annual dues revenue may be utilized for this purpose.

INTERPRETATION NO. 33

(Adopted February 5, 1974)
(Revised May 19, 1997)

"It is an inequitable limitation to deny membership to an applicant who maintains an office for the conduct of a real estate business, recognized in the community, and who holds himself out to the public as being actively engaged in real estate business solely upon the grounds the applicant is not so engaged."

This Interpretation does not contemplate that the broker must devote all or even a majority of his time to his real estate business or derive any particular percentage of his income from such business. It does not contemplate that the licensee shall have no other job or occupation. It does contemplate that the licensee shall actively seek real estate business; that he shall maintain and adequately supervise a real estate office.

Where question arises as to whether or not a licensee is "actively engaged" in the real estate business, he shall be given the opportunity to present evidence concerning the actual and intended nature and scope of his business activities.

INTERPRETATION NO. 34

(Adopted November 12, 1974)

"It shall be an inequitable limitation for a Board to require a separate office in each Multiple Listing Service area where there is more than one Multiple Listing Service owned or controlled by the Board within the jurisdiction of the Board in order to participate in each such Multiple Listing Service."

A REALTOR® is entitled to participate in any and all services and programs sponsored by the Board of REALTORS®. A Board rule which circumscribes the right to such participation restricts and limits the conditions of Board Membership in violation of Article I, Section 2, of the Bylaws of the NATIONAL ASSOCIATION OF REALTORS®.

To institute a divisional Multiple Listing Service based on geographic lines within a Board jurisdictional area limits access to Board services and activities in a way which could be deemed and adjudged arbitrary and unreasonable.

As such, it is merely an extension of Interpretation No. 25 in that it refers specifically to the right of a REALTOR® to participate in a Board owned and controlled Multiple Listing Service and any geographic division thereof without the necessity of having an office within said geographic division.

INTERPRETATION NO. 35

(Adopted November 13, 1979)
(Revised May 19, 1997)

"That it is an inequitable limitation on membership for a Board of REALTORS® to have a rule or regulation limiting members of a franchise organization, referral group, or broker affiliation of any kind, with respect to service on the Board of Directors or Committees in any elective or appointed capacity."

This Interpretation is a further application of the principal established by Interpretation 28 and like that Interpretation is founded on the Preamble of the Code of Ethics.

Service is an elective or appointed capacity in a Board of REALTORS® is both a right and duty of membership. A Board may not restrict such service unless such restriction is necessary to maintain the integrity and independence of the Board and assure balanced service to all members.

Under this Interpretation, membership in a franchise, referral service, or other affiliated group of brokers may not, per se, justify exclusion from election or appointment.

This Interpretation does not, however, preclude a Board from reasonably limiting the number of REALTOR® or REALTOR-ASSOCIATE® Members of the same firm or firms having common ownership who may hold elective or appointive positions.

INTERPRETATION NO. 36

(Adopted November 13, 1979)
(Revised May 10, 1988)
(Deleted May 19, 1997)

INTERPRETATION NO. 37

(Adopted May 10, 1983)
(Revised February 6, 1989)

"A Board rule requiring that Board Members attend, on at least a biennial basis, a continuing education program comprised of not more than six (6) cumulative hours of instruction with respect to Board or Member practices that might result in a significant legal vulnerability and possible liability to the Board and its Members, such as violations of anti-trust laws, agency laws, civil rights laws, the Code of Ethics of the National Association, or other similar public policies is not an inequitable limitation upon membership."

The National Association has long maintained a policy that it is inappropriate for a Board to have any mandated educational requirements other than a requirement for prospective Members or current Members to be familiar with the Constitution and Bylaws of the local Board, State Association, and National Association, the Code of Ethics of the National Association, and any rules, regulations, practices, policies or procedures of the Board that relate to being a knowledgeable and informed Member of the Board. It is not appropriate to require competency and licensure training which is provided by the state. However, when there is a clear and present danger that polices and practices of the Board or of its Members may result in significant legal vulnerability and liability to the organization and its members, it is reasonable to require that Board Member participate in a program sponsored by the Board to assist and educate Members in areas of high legal vulnerability.

Mandatory attendance should only be required at programs related to matters that, if education were not provided, might result in a significant legal vulnerability and possible liability to the Board and its members, such as violations of anti-trust laws, agency laws, civil rights laws, the Code of Ethics of the National Association, or other similar public policies.

The mandatory nature of the programs should be clearly established in the Board's Bylaws. Every effort should be made to make all Members aware of this requirement far enough in advance to allow them to make arrangements to attend. In the event that some form of discipline will be imposed for failure to meet the mandatory attendance requirement, then the discipline that will be imposed should also be clearly spelled out in the Board's Bylaws. In the event that certain Members hold membership in more than one Board, consideration should be given to granting of a "credit" if the Member has attended a similar program conducted by another Board.

INTERPRETATION NO. 38

(Adopted May 10, 1983)

"A provision in the Bylaws of a Board which offers the opportunity to a former Member having been dropped for nonpayment of membership dues during the current fiscal year to be reinstated without reapplication and payment of an application fee, but requiring payment of all past due accounts and payment of membership dues for the entire fiscal year, is not an inequitable limitation upon membership."

The Model Bylaws recommended by the National Association to local Boards provide that when a Member is dropped from membership, the Member may be further considered for membership in the Board upon applying in the same manner and paying the same application fees, if any, required of any applicant for membership. Therefore, if a Board Member receives services of the Board, and of the State and National Associations, for a period of the current fiscal year, it is not equitable for the Board to

require that individual seeking reinstatement of membership in the same fiscal year to pay the full membership dues for the entire year, plus any past due accounts or other monies owed to the Board, without having to go through the process of making application, taking the required orientation course, and paying any required application fee.

INTERPRETATION NO. 39

(Adopted November 12, 1985)

"No Member Board of REALTORS® shall knowingly schedule any board function at a place or in a facility that denies admittance to that function to any individual on the basis of race, creed, sex, or country of national origin."

INTERPRETATION NO. 40

(Adopted November 18, 1996)

"The term "principal," as used in the NAR Constitution and Bylaws and in other relevant policies, includes licensed or certified individuals who are sole proprietors, partners in a partnership, officers or majority shareholders of a corporation, or office managers (including branch office managers) acting on behalf of principals of a real estate firm."

Clarifies the definition of the term "principal" as used in the NAR Constitution and Bylaws and in other relevant policies.

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The **REALTORS® Dental Insurance** plans are the only dental plans designed exclusively for NAR members and their families. Plans provide coverage for preventive, basic, and major dental expenses with the dentist of your choice. There are 4 plans to choose from and most plans include bonus benefits like orthodontia, cosmetic, dental rewards, and more.

With over 1 million members, the NAR qualifies for large group dental benefits and rates, similar to those of large employers.

REALTORS® Dental Plan Benefits

Over 300 covered procedures. Highlights include:
Hide Benefits

- **Preventive Dental Benefits (no deductible)**: Routine exams, cleanings, fluoride treatments, sealants, and more.
- **Basic Dental Benefits**: Full mouth X-rays, bitewings, amalgam restoration (silver filings), simple and complex extractions, surgical removal of teeth, deep sedation/general anesthesia, and more.
- **Major Dental Benefits**: Onlays, maxillary partial denture – resin base, senture repair, endodontics – root canal, periodontal scaling and root planning, crown and crown repairs, pontics - porcelain fused to noble metal, and more.

Bonus Benefits: Orthodontia, Cosmetic, and More

As a member of one of the largest associations in the nation, you get

VIEW MEMBER EXCLUSIVE PLANS & RATES

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* Birthdate Month Day Year
* Zip Code
* Contact Method By Email
Phone Number - -
* Email
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* Cover Spouse? No
* Dependents None

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Note - You may be contacted by one of our representatives to assist you.

bonus benefits similar to large group plan members. Bonus benefits are available with Platinum, Gold, and Silver Plans.
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- **Orthodontia Benefits**: A lifetime benefit available to dependent children of the plan.
- **Cosmetic Benefits**: Professional tooth bleaching, also referred to as whitening, has become a popular cosmetic procedure. With this benefit, plan members can enjoy having a healthy, white smile that will boost self-confidence and add sparkle to their appearance.
- **Dental Rewards**: A valuable feature which allows qualifying plan members to carryover part of their unused annual maximum.
- **Laser Vision Correction Coverage Benefit**: LASIK Advantage provides coverage for LASIK and related procedures, including standard LASIK, Custom LASIK, LASIK with Wavefront Technology, Custom Vue LASIK, LASIK with IntraLase technology and Photorefractive Keratectomy (PRK). Members earn a lifetime benefit per eye over time.

REALTORS® Dental Plan Highlights

Hide Highlights

- **Eligibility**: As long as you are a member of the NAR you are eligible for these valuable dental plans.
- **Freedom of choice**: You're free to visit any licensed dentist. These plans do have a preferred network (PPO) of dentists available nationwide; your out-of-pocket costs will decrease significantly if you visit a PPO dentist.
- **Large nationwide network (PPO)**: When you visit a participating Ameritas Dental PPO provider, you save money. Ameritas PPO providers have agreed to charge reduced fees to member clients. The Ameritas Dental network is comprised of more than 83,000 dentist locations nationwide. You can use a simple online directory to easily find a provider in your area. PPO dentists must meet Ameritas credentialing and quality assurance evaluation requirements.
- **Claims convenience**: You will receive an ID card to present to your dentist at the time of service. The dentist can submit bills to Ameritas, which will pay the dentist directly. You'll receive an Explanation of Benefits (EOB) statement, which will explain how benefits were covered. For your information, claims are available to view online at any time.
- **Maximum Covered Expense (MCE)**: MCE is an easy-to-understand benefit at a very affordable rate. You know exactly what the plan pays for each covered procedure, and pay the difference between that amount and the dentist's fee. You will receive additional out-of-pocket savings when using an Ameritas PPO provider.

Some Interesting Dental Facts...

- **Easy online billing**: You may pay your bill online or have your premiums automatically deducted from your account. You can access your account 24/7 and receive email alerts to be notified of upcoming withdrawals.
- **Personal service**: You will have access to professional US customer service support from 7a.m. to 7p.m. (CST). We want you to understand your coverage and be satisfied with the results.
- **Credit for existing plans**: If you have existing coverage under another dental plan you may enroll in the REALTORS® Dental Plan and receive carry over credit for meeting waiting periods.

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REALTORS®
DentalInsurance

A valuable Dental Insurance benefit for members of the NAR

The National Association of Realtors is excited to offer its members a new dental program! By sponsoring the plan and acting as policyholder for the plan, the NAR brings buying power to its members in providing a choice of affordable plan options. We encourage members to review the four plan choices to consider which plan best fits their dental wellness and cost needs.

Eligible members have a choice between four plan options (Gold, Silver, Bronze and Value plans). Whichever plan is chosen, the member must remain in that plan for 12 months and may not make changes in election except for certain "life" events.

Members can cover eligible dependents, and dependents would receive the same plan option chosen by the member.

REALTORS® Dental Plan Benefits

Over 300 covered procedures

- **Preventive Dental Benefits (no deductible)**: Routine exams, cleanings, fluoride treatments, sealants, and more.
- **Basic Dental Benefits**: Full mouth X-rays, bitewings, amalgam restoration (silver filings), simple and complex extractions, surgical removal of teeth, deep sedation/general anesthesia, and more.
- **Major Dental Benefits**: Onlays, maxillary partial denture – resin base, senture repair, endodontics – root canal, periodontal scaling and root planning, crown and crown repairs, pontics - porcelain fused to noble metal, and more.

Bonus Benefits: Orthodontia, Cosmetic, and More

As a member of one of the largest associations in the nation, you get bonus benefits similar to large group plan members. Bonus benefits are available with Platinum, Gold, and Silver Plans.

- **Orthodontia Benefits**: A lifetime benefit available to dependent children of the plan.
- **Cosmetic Benefits**: Professional tooth bleaching, also referred to as whitening, has become a popular cosmetic procedure. With this benefit, plan members can enjoy having a healthy, white smile that will boost self-confidence and add sparkle to their appearance.
- **Dental Rewards**: A valuable feature which allows qualifying plan members to carryover part of their unused annual maximum.
- **Laser Vision Correction Coverage Benefit**: LASIK Advantage provides coverage for LASIK and related procedures, including standard LASIK, Custom LASIK, LASIK with Wavefront Technology, Custom Vue LASIK, LASIK with IntraLase technology and Photorefractive Keratectomy (PRK). Members earn a lifetime benefit per eye over time.

REALTORS® Dental Plan Highlights

- **Eligibility**: As long as you are a member of the NAR you are eligible for these valuable dental plans.
- **Freedom of choice**: You're free to visit any licensed dentist. These plans do have a preferred network (PPO) of dentists available nationwide; your out-of-pocket costs will decrease significantly if you visit a PPO dentist.
- **Large nationwide network (PPO)**: When you visit a participating Ameritas Dental PPO provider, you save money. Ameritas PPO providers have agreed to charge reduced fees to member clients. The Ameritas Dental network is comprised of more than 83,000 dentist locations nationwide. You can use a simple online directory to easily find a provider in your area. PPO dentists must meet Ameritas credentialing and quality assurance evaluation requirements.
- **Claims convenience**: You will receive an ID card to present to your dentist at the time of service. The dentist can

submit bills to Ameritas, which will pay the dentist directly. You'll receive an Explanation of Benefits (EOB) statement, which will explain how benefits were covered. For your information, claims are available to view online at any time.

- **Maximum Covered Expense (MCE)**: MCE is an easy-to-understand benefit at a very affordable rate. You know exactly what the plan pays for each covered procedure, and pay the difference between that amount and the dentist's fee. You will receive additional out-of-pocket savings when using an Ameritas PPO provider.
- **Easy online billing**: You may pay your bill online or have your premiums automatically deducted from your account. You can access your account 24/7 and receive email alerts to be notified of upcoming withdrawals.
- **Personal service**: You will have access to professional US customer service support from 7a.m. to 7p.m. (CST). We want you to understand your coverage and be satisfied with the results.
- **Credit for existing plans**: If you have existing coverage under another dental plan you may enroll in the REALTORS® Dental Plan and receive carry over credit for meeting waiting periods.

A sampling of the covered procedures along with each plan's maximum covered expenses is shown in this illustration. A complete schedule of benefit and maximum covered expense can be accessed at the rate and plan design section of the website (you must login).

Example of PPO vs. Out of Network Savings:

Bob, who lives in the Chicago area (ZIP 60156), visits the dentist two times each year for his annual checkup and gets an exam, cleaning, and x-rays. The dentist discovers that Bob needs two fillings and an extraction of two impacted wisdom teeth. Here is an example of how the plan could work if Bob selects the Silver or the Gold plan.

Procedure/Procedure Code	Dentist's average charge in the area	PPO Provider Negotiated Fee	Maximum Allowable Expense Under the NAR Gold Plan	Maximum Allowable Expense Under the NAR Platinum Plan
Comprehensive exam, #D0150	$59	$38	$43	$51
Adult cleaning, #D1110	$75	$50	$60	$70
Bitewing x-rays, #D0272	$36	$22	$26	$30
Filling (restorative amalgam), #D2140	$102	$68	$60	$70
Complex extraction, #D7230	$343	$226	$214	$250
TOTAL	$615	$404	$403	$471
X 2 visits per year				
Total Annual Expense	$1,230	$808	$806	$870
			- $50 Deductible	- $50 Deductible
			$756 Benefits Available For Bob's claims	$820 Benefits Available For Bob's claims

If Bob uses a PPO provider for services, under the Silver Plan, Bob's out of pocket expense would be $52. If Bob uses an out-of-network dentist, Bob will share more of the cost of his services, with his out-of-pocket expense being $474.

If Bob uses a PPO provider for services, under the Gold Plan, Bob's out-of-pocket expense would be $0, as the Gold plan would fully cover the PPO provider's negotiated fees for the services Bob needed. If Bob uses an out-of-network dentist, Bob will share more of the cost of his services with his out-of-pocket expense being $420.

REALTORS® DentalInsurance

The REALTORS® Dental Insurance (RDI) is offered through NAR's REALTOR Benefits® Program in partnership with Ameritas Life Insurance Corp.; and SASid (Smart And Simple insurance development).

SASid insurance development

SASid Insurance Development (SASid):

SASid develops technologies and online insurance products for top insurance carriers and nationwide distribution networks. SASid was founded in 1999 and has been a leader and innovator in developing and marketing insurance on the web. SASid was founded by insurance professionals who have a passion to make insurance programs more simple and smart. SASid is located in Janesville, Wisconsin.

SASid provides the following for REALTORS® Dental Insurance:

- Policyholder services and customer support.
- Customer enrollment
- Policyholder Billing

Phone SASid: 1-877-CORE-PLAN 1-877-267-3752
or email at RDI@sasid.com

AMERITAS GROUP

Ameritas Life Insurance Corp.

Our process is very simple: we do whatever it takes to help our customers get the care they need. And whatever it takes includes:

- Processing more than 3.6 million dental claims each year.
- Having a claims processing turnaround time of 90% in 5-7 working days.
- Being so meticulous that our accuracy of processed claims exceeds 99%.
- Putting into place a high-tech electronic claims system specifically designed for processing dental claims.
- Accurately processing customized deductibles, coinsurance levels, maximums and claim allowance

Financial Strength Ratings

The financial strength and operating performance of Ameritas Life Insurance Corp., Acacia Life Insurance Company, The Union Central Life Insurance Company and First Ameritas Life Insurance Corp. of New York are reflected in strong group ratings by independent rating agencies.

A.M. Best Rating:

A (Excellent) for financial strength and operating performance. This is the third highest of A.M. Best's 15 ratings.

NATIONAL ASSOCIATION OF REALTORS®

The National Association of Realtors®(NAR), "The Voice for Real Estate," is America's largest trade association, representing over 1 million Realtors® involved in all aspects of the residential and commercial real estate industries.

NAR's REALTOR Benefits® Program provides members with access to value-added offers and savings on a variety of products and services that they use every day. This program includes partners in the following categories: Insurance & Warranties, Financial Services, Marketing, Technology, Travel, Office Solutions and Educational Tools. For more information visit www.REALTOR.org/RealtorBenefits or call 1-800-NAR-5233

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**NATIONAL ASSOCIATION OF REALTORS**		
		Policy Number	**10-350635**
State of Delivery	**Illinois**	**Plan Effective Date**	**January 1, 2010**
Premium Due Date 1st of each month.		**Renewal Date**	**January 1, 2012**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

AMERITAS LIFE INSURANCE CORP.

Jan M. Connolly
Secretary

JoAnn M Martin
President

Notice of Grievance Procedures

In accordance with the Dental Care Patient Protection Act of the Illinois Insurance Code

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free)
402-309-2579 (FAX)

Please read this notice carefully. This notice contains important information about how to file grievances with your insurer. If you have questions, please feel free to contact the toll-free number shown above. Also, you always have the right to contact the Illinois Department of Insurance if you have a question or concern regarding your coverage under this contract. The Illinois Department may be contacted:

In Writing:	Illinois Department of Financial & Professional Regulation Division of Insurance Office of Consumer Health Insurance 320 West Washington Street Springfield, IL 62767-0001
By toll-free phone:	877-527-9431

I. Definitions

"Adverse Determination" means a determination by a health carrier that a health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced or terminated.

"Covered Person" means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

"Grievance" means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

(a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;

(b) claims payment, handling, or reimbursement for health care services;

(c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Review Process

You may ask your insurer to review its decisions involving your requests for benefit estimates or your requests to have your claims paid.

A written grievance concerning any matter, including an adverse determination may be submitted by a covered person. A written decision to the covered person will be provided within 15 working days after receiving a grievance and all information necessary for the insurer's review of the grievance. The person

or persons reviewing the grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If a decision cannot be made within 15 working days due to circumstances beyond the insurer's control, the insurer may take up to an additional 15 working days to issue a written decision.

III. Written Decision

When a decision is issued after the review, the following information will be included in the written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review process;
2. a statement of the reviewer's understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;
4. notice of the covered person's right to contact the Illinois Department of Insurance.

ILLINOIS
LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631-3404
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes And Current Limitations of Coverage

The Illinois law that provides for this safety net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

(please turn to other side)

1. Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

a. life insurance, health insurance, and annuity contracts;
b. life, health or annuity certificates under direct group policies or contracts;
c. unallocated annuity contracts; and
d. contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

2. Exclusions from Coverage:
   a. The Guaranty Association does not provide coverage for:

      i. any policy or portion of a policy for which the individual has assumed the risk;
      ii. any policy of reinsurance (unless an assumption certificate was issued);
      iii. interest rate guarantees which exceed certain statutory limitations;
      iv. certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
      v. any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
      vi. any stop loss insurance.

   b. In addition, persons are not protected by the Guaranty Association if:

      i. the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
      ii. their policy was issued by an organization which is not a member insurer of the Association.

3. Limits on Amount of Coverage:
   a. The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:

      i. the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
      ii. with respect to any one life, regardless of the number of policies, contracts, or certificates:

         1) in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
         2) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
         3) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

   b. However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	Member Electing The Gold Plan
Class 2	Member Electing The Silver Plan
Class 3	Member Electing The Bronze Plan
Class 4	Member Electing The Value Plan
Class 5	Member Electing The Gold Plan
Class 6	Member Electing The Silver Plan
Class 7	Member Electing The Bronze Plan

Class Number 1

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,400

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 2

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 3

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 4

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Type 2 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	$1,000

Class Number 5

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period $1,400

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 6

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period $1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 7

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 1

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 2

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 3

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 4

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 5

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 6

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 7

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 1

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on November 1, 2009

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 2

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on November 1, 2009

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 3

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on November 1, 2009

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 5

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on November 1, 2009

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 6

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on November 1, 2009

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 7

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on November 1, 2009

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Classes 01,05	
Dental Care Insurance	$39.08 per Insured Person
	$34.24 Spouse Only
	$55.08 Child(ren) Only
	$89.32 Spouse & Child(ren)
Classes 02,06	
Dental Care Insurance	$30.36 per Insured Person
	$26.52 Spouse Only
	$42.64 Child(ren) Only
	$69.16 Spouse & Child(ren)
Classes 03,07	
Dental Care Insurance	$24.08 per Insured Person
	$20.96 Spouse Only
	$33.60 Child(ren) Only
	$54.56 Spouse & Child(ren)
Class 4	
Dental Care Insurance	$15.84 per Insured Person
	$13.60 Spouse Only
	$27.36 Child(ren) Only
	$40.96 Spouse & Child(ren)
Classes 01,05	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.08 Child(ren) Only

	$5.08 Spouse & Child(ren)
Classes 02,06	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.16 Child(ren) Only
	$5.16 Spouse & Child(ren)
Classes 03,07	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.28 Child(ren) Only
	$5.28 Spouse & Child(ren)
Classes 01,05	
Laser Vision Correction Insurance	$1.52 per Insured Person
	$1.52 Spouse Only
	$0.80 Child(ren) Only
	$2.32 Spouse & Child(ren)
Classes 02,06	
Laser Vision Correction Insurance	$1.56 per Insured Person
	$1.56 Spouse Only
	$0.84 Child(ren) Only
	$2.40 Spouse & Child(ren)
Classes 03,07	
Laser Vision Correction Insurance	$1.60 per Insured Person
	$1.60 Spouse Only
	$0.84 Child(ren) Only
	$2.44 Spouse & Child(ren)

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of one or both of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date.

Should either or both of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

Class Number 1

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

   iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who:

   i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

   ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

      "Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

      Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's

attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 2

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 3

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 4

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services

licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 5

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 6

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military

dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 7

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

All Classes

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

Class Number 1

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing the gold plan working a minimum number of hours per week as required by the Policyholder. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member electing the gold plan working a minimum number of hours per week as required by the Policyholder and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 2

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing the silver plan working a minimum number of hours per week as required by the Policyholder. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered

from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member electing the silver plan working a minimum number of hours per week as required by the Policyholder and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

<u>Class Number 3</u>

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing the bronze plan working a minimum number of hours per week as required by the Policyholder. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member electing the bronze plan working a minimum number of hours per week as required by the Policyholder and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 4

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing the value plan working a minimum number of hours per week as required by the Policyholder. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member electing the value plan working a minimum number of hours per week as required by the Policyholder and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

<u>Class Number 5</u>

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing the gold plan working a minimum number of hours per week as required by the Policyholder. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member electing the gold plan working a minimum number of hours per week as required by the Policyholder and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 6

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing the silver plan working a minimum number of hours per week as required by the Policyholder. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member electing the silver plan working a minimum number of hours per week as required by the Policyholder and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 7

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing the bronze plan working a minimum number of hours per week as required by the Policyholder. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member electing the bronze plan working a minimum number of hours per week as required by the Policyholder and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

All Classes

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

Class Number 1

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 2

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 3

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 4

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 5

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 6

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 7

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

All Classes

CONTINUATION OF COVERAGE

Death, Divorce or Separation
For Spouses and Dependents

1. The Insured's spouse may continue coverage for themselves and any dependent children if coverage would terminate as a result of:

    a. the death of the Insured; or
    b. the dissolution of a marriage with, or legal separation from, the Insured.
    c. the retirement of the Insured. (In this instance, the spouse must be at least age 55 on the date of retirement in order to elect continuation under this provision.)

    provided:
        i. the spouse makes election for continuation of coverage in the required time frames; and
        ii. any required premium is paid.

2. Benefits

    This continuation applies to all benefits payable under the policy.

3. How to Apply

    a. Within 30 days of the entry of judgment of divorce or legal separation, or the death or retirement of the Insured, the spouse must notify the employer, including a mailing address, if he or she wishes to elect continuation of coverage.
    b. Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the dissolution of the marriage or the death or retirement of the Insured.

    c. Within 30 days after the date of receipt of a notice from the employer, we shall provide notice in writing the following:

        i. an election form;
        ii. the premium due;
        iii. when and how payments must be made;
        iv. instructions on returning the election form.

    d. The spouse must affirmatively elect continuation with payment of the first monthly premium within 30 days of the date the notice is mailed by the insurer. Failure to elect continuation of coverage during this period shall terminate any future right to continuation.

4. Failure to Notify

    If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent.

5. Premiums

a. For former spouses who have not attained the age of 55 at the time coverage begins, the monthly premium shall be equal to the amount charged an employee if the former spouse were a current employee plus the amount the employer would contribute toward the premium if the former spouse were a current employee.

b. For former spouses who have attained the age of 55 at the time coverage begins, the monthly premium shall be based on the same calculation as defined in 5.a. above. However, beginning 2 years after coverage begins, the monthly premium shall be based on this same calculation, plus an additional amount, not to exceed 20% of this calculation for costs of administration.

6. Termination

For former spouses who have not attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

a. the last day of the period for which the premium is paid;
b. the date that coverage would terminate under the terms of the existing policy if the Insured and spouse were still married to each other;
c. the date the spouse becomes insured under another group health plan;
d. the date the spouse remarries;
e. the expiration of 2 years from the date coverage began;
f. the date the policy terminates.

For former spouses who have attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

a. the last day of the period for which the premium is paid;
b. the date on which coverage would terminate, except due to the retirement of an employee, under the terms of the existing policy if the Insured and spouse were still married to each other;
c. the date the spouse becomes insured under another group health plan;
d. the date the spouse remarries;
e. the date the spouse is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act;
f. the date the policy terminates.

7. Replacement of Policy
A new insurance carrier replacing coverage under which a continued person is covered must take over and continue such person's coverage.

Death of the Insured
Attainment of Limiting Age
Dependent Children

1. The Insured's dependent child may continue coverage under this policy
   a. in the event of the death of the Insured and the child is not eligible for coverage as a dependent under the provisions stated above; or
   b. the dependent child has attained the limiting age under the policy.

2. This continuation applies to all benefits payable under the policy.

3. How to Apply
   a. Death of the Insured

Within 30 days of the death of the Insured, the dependent child or a responsible adult acting on behalf of the child must notify the employer or the insurer if he or she wishes to elect continuation of coverage.

Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the death of the Insured and the mailing address of the dependent child. The employer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence.

b. Attainment of Limiting Age

In the event of the dependent child attaining the limiting age under the policy, if continuation coverage is desired, the dependent child shall give the employer or the insurer written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

Within 15 days of receipt of notice, the employer must mail us, the insurer, notice of the request to continue coverage under this provision including the mailing address of the dependent child. The employer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence

4. Responsibilities of the Insurer

Within 30 days after the date of receipt of a notice from the employer, we shall provide notice in writing by certified mail, return receipt requested, notification to the dependent child or responsible adult that the policy may be continued. In addition, the notice will include:

i. an election form;
ii. the premium due;
iii. when and how payments must be made;
iv. instructions on returning the election form within thirty (30) days after the date it is received.

5. Electing Coverage

The dependent child or the responsible adult acting on behalf of the dependent child to exercise the election to continue coverage within such 30 day period shall terminate the continuation of benefits and the right to continuation.

6. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent and benefits will continue under the terms and provisions of the policy except where the benefits in existence at the time the company's notice was to be sent are terminated as to all employees.

7. Premiums

The monthly premium will be equal to:

a. an amount, if any, that would be charged an employee if the dependent child were a current employee of the employer, plus;
b. an amount, if any, that the employer would contribute toward the premium if the dependent child were a current employee.

Failure to pay the initial monthly premium within 30 days after the date of receipt of notice as defined in subsection (4) of this provision terminates the continuation benefits and the right to continuation benefits.

8. Termination

Coverage under this provision will terminate upon the earliest of:

a. the last day of the period for which the premium is paid;
b. the date that coverage would terminate under the terms of the existing policy if the dependent child

was still an eligible dependent of the employee;

c. the date on which the dependent child first becomes, or after the date of election, an insured employee under any other group policy; or

d. the expiration of 2 years from the date continuation coverage began.

9. Replacement of Policy

If the group policy is cancelled and another insurance company contracts to provide group coverage to the employer, and continuation coverage is in effect for the dependent child at the time of cancellation, and the employee is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the dependent child under the same terms and conditions as contained in this provision.

DENTAL EXPENSE BENEFITS

Class Number 1

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits

provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

Class Number 2

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is

amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under

this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

Class Number 3

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any

such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

Class Number 4

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

2. for any procedure begun after the insured person's insurance under this contract terminates.

3. to replace lost or stolen appliances.

4. for any treatment which is for cosmetic purposes.

5. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

6. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

7. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

8. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

9. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

10. because of war or any act of war, declared or not.

Class Number 5

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown,

appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11. because of war or any act of war, declared or not.

<u>Class Number 6</u>

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally

accepted parameters of care.

11. because of war or any act of war, declared or not.

Class Number 7

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

Class Number 1

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 2

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 3

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 4

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 5

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 6

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 7

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

All Classes

- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.

- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).

- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.

- B/R means By Report.

- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.

- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.

- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Class Number 1

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$33.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$25.00
D0150	Comprehensive oral evaluation - new or established patient.	$50.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$50.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$16.00
D0272	Bitewings - two films.	$30.00
D0273	Bitewings - three films.	$36.00
D0274	Bitewings - four films.	$46.00
D0277	Vertical bitewings - 7 to 8 films.	$70.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$70.00
D1120	Prophylaxis - child.	$49.00
D1203	Topical application of fluoride - child.	$27.00
D1204	Topical application of fluoride - adult.	$27.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$27.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT		
D1351	Sealant - per tooth.	$38.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).

TYPE 1 PROCEDURES

		Maximum Covered Expense
	• Benefits are considered for persons age 16 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only.	
SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$246.00
D1515	Space maintainer - fixed - bilateral.	$402.00
D1520	Space maintainer - removable - unilateral.	$385.00
D1525	Space maintainer - removable - bilateral.	$469.00
D1550	Re-cementation of space maintainer.	$50.00
D1555	Removal of fixed space maintainer.	$70.00
	SPACE MAINTAINER: D1510, D1515, D1520, D1525 • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.	
APPLIANCE THERAPY		
D8210	Removable appliance therapy.	$370.00
D8220	Fixed appliance therapy.	$370.00
	APPLIANCE THERAPY: D8210, D8220 • Coverage is limited to the correction of thumb-sucking.	

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$41.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$41.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$83.00
D0330	Panoramic film.	$67.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$15.00
D0230	Intraoral - periapical each additional film.	$12.00
D0240	Intraoral - occlusal film.	$21.00
D0250	Extraoral - first film.	$27.00
D0260	Extraoral - each additional film.	$21.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$49.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$97.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$97.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$70.00
D2150	Amalgam - two surfaces, primary or permanent.	$89.00
D2160	Amalgam - three surfaces, primary or permanent.	$107.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$128.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$85.00
D2331	Resin-based composite - two surfaces, anterior.	$107.00
D2332	Resin-based composite - three surfaces, anterior.	$134.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$148.00
D2391	Resin-based composite - one surface, posterior.	$93.00
D2392	Resin-based composite - two surfaces, posterior.	$118.00
D2393	Resin-based composite - three surfaces, posterior.	$148.00
D2394	Resin-based composite - four or more surfaces, posterior.	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$70.00
D2420	Gold foil - two surfaces.	$89.00
D2430	Gold foil - three surfaces.	$107.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$181.00
D2930	Prefabricated stainless steel crown - primary tooth.	$152.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$161.00
D2932	Prefabricated resin crown.	$181.00
D2933	Prefabricated stainless steel crown with resin window.	$181.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$181.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$56.00
D2915	Recement cast or prefabricated post and core.	$28.00
D2920	Recement crown.	$55.00
D6092	Recement implant/abutment supported crown.	$55.00
D6093	Recement implant/abutment supported fixed partial denture.	$55.00
D6930	Recement fixed partial denture.	$76.00

SEDATIVE FILLING

D2940	Sedative filling.	$51.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$86.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$89.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$89.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$74.00
D5610	Repair resin denture base.	$88.00
D5620	Repair cast framework.	$104.00
D5630	Repair or replace broken clasp.	$109.00
D5640	Replace broken teeth - per tooth.	$78.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5731	Reline complete mandibular denture (chairside).	$162.00
D5740	Reline maxillary partial denture (chairside).	$146.00
D5741	Reline mandibular partial denture (chairside).	$147.00
D5750	Reline complete maxillary denture (laboratory).	$243.00
D5751	Reline complete mandibular denture (laboratory).	$238.00
D5760	Reline maxillary partial denture (laboratory).	$243.00
D5761	Reline mandibular partial denture (laboratory).	$244.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$78.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$78.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$151.00
D7220	Removal of impacted tooth - soft tissue.	$188.00
D7230	Removal of impacted tooth - partially bony.	$250.00
D7240	Removal of impacted tooth - completely bony.	$292.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$333.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$156.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$369.00
D7261	Primary closure of a sinus perforation.	$369.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$223.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$223.00
D7280	Surgical access of an unerupted tooth.	$345.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$249.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$104.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$130.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$65.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$165.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$83.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$238.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$592.00
D7410	Excision of benign lesion up to 1.25 cm.	$236.00
D7411	Excision of benign lesion greater than 1.25 cm.	$302.00
D7412	Excision of benign lesion, complicated.	$333.00
D7413	Excision of malignant lesion up to 1.25 cm.	$319.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$233.00
D7415	Excision of malignant lesion, complicated.	$257.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$319.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$233.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$71.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$210.00
D7472	Removal of torus palatinus.	$210.00
D7473	Removal of torus mandibularis.	$210.00
D7485	Surgical reduction of osseous tuberosity.	$342.00
D7490	Radical resection of maxilla or mandible.	$319.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$105.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$121.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$97.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$266.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$266.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$350.00
D7910	Suture of recent small wounds up to 5 cm.	$47.00
D7911	Complicated suture - up to 5 cm.	$53.00
D7912	Complicated suture - greater than 5 cm.	$76.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$253.00
D7963	Frenuloplasty.	$316.00
D7970	Excision of hyperplastic tissue - per arch.	$195.00
D7972	Surgical reduction of fibrous tuberosity.	$310.00
D7980	Sialolithotomy.	$292.00
D7983	Closure of salivary fistula.	$93.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$316.00
D7286	Biopsy of oral tissue - soft.	$170.00
D7287	Exfoliative cytological sample collection.	$85.00
D7288	Brush biopsy - transepithelial sample collection.	$85.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$58.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$224.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$74.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$148.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$36.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$60.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$41.00
D9440	Office visit - after regularly scheduled hours.	$72.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$44.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$56.00
D9952	Occlusal adjustment - complete.	$281.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$49.00
D2951	Pin retention - per tooth, in addition to restoration.	$27.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$85.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$305.00
D2520	Inlay - metallic - two surfaces.	$363.00
D2530	Inlay - metallic - three or more surfaces.	$391.00
D2610	Inlay - porcelain/ceramic - one surface.	$336.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$366.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$401.00
D2650	Inlay - resin-based composite - one surface.	$349.00
D2651	Inlay - resin-based composite - two surfaces.	$345.00
D2652	Inlay - resin-based composite - three or more surfaces.	$357.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$396.00
D2543	Onlay - metallic - three surfaces.	$441.00
D2544	Onlay - metallic - four or more surfaces.	$459.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$396.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$443.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$456.00
D2662	Onlay - resin-based composite - two surfaces.	$371.00
D2663	Onlay - resin-based composite - three surfaces.	$382.00
D2664	Onlay - resin-based composite - four or more surfaces.	$406.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$173.00
D2712	Crown - 3/4 resin-based composite (indirect).	$428.00
D2720	Crown - resin with high noble metal.	$441.00
D2721	Crown - resin with predominantly base metal.	$336.00
D2722	Crown - resin with noble metal.	$413.00
D2740	Crown - porcelain/ceramic substrate.	$476.00
D2750	Crown - porcelain fused to high noble metal.	$463.00
D2751	Crown - porcelain fused to predominantly base metal.	$397.00
D2752	Crown - porcelain fused to noble metal.	$425.00
D2780	Crown - 3/4 cast high noble metal.	$440.00
D2781	Crown - 3/4 cast predominantly base metal.	$383.00
D2782	Crown - 3/4 cast noble metal.	$400.00
D2783	Crown - 3/4 porcelain/ceramic.	$476.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$440.00
D2791	Crown - full cast predominantly base metal.	$383.00
D2792	Crown - full cast noble metal.	$400.00
D2794	Crown - titanium.	$440.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$96.00
D6973	Core build up for retainer, including any pins.	$96.00

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$153.00
D2954	Prefabricated post and core in addition to crown.	$127.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$77.00
D6980	Fixed partial denture repair, by report.	$86.00
D9120	Fixed partial denture sectioning.	$86.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$61.00
D3221	Pulpal debridement, primary and permanent teeth.	$61.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$91.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$81.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$70.00
D3333	Internal root repair of perforation defects.	$99.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$99.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$67.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$197.00
D3430	Retrograde filling - per root.	$78.00
D3450	Root amputation - per root.	$185.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$156.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$277.00
D3320	Endodontic therapy, bicuspid tooth.	$326.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$427.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$163.00
D3346	Retreatment of previous root canal therapy - anterior.	$345.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$397.00
D3348	Retreatment of previous root canal therapy - molar.	$493.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$285.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$328.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$355.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$127.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$180.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$90.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$247.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$124.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$454.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$227.00
D4263	Bone replacement graft - first site in quadrant.	$148.00
D4264	Bone replacement graft - each additional site in quadrant.	$111.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$74.00
D4270	Pedicle soft tissue graft procedure.	$334.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$354.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$413.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$199.00
D4275	Soft tissue allograft.	$354.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$413.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 3 PROCEDURES

		Maximum Covered Expense
CROWN LENGTHENING		
D4249	Clinical crown lengthening - hard tissue.	$273.00
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$93.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$46.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$68.00

CHEMOTHERAPEUTIC AGENTS: D4381
- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$493.00
D5120	Complete denture - mandibular.	$478.00
D5130	Immediate denture - maxillary.	$534.00
D5140	Immediate denture - mandibular.	$517.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$354.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$354.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$410.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$306.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$354.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$410.00
D5810	Interim complete denture (maxillary).	$218.00
D5811	Interim complete denture (mandibular).	$230.00
D5820	Interim partial denture (maxillary).	$191.00
D5821	Interim partial denture (mandibular).	$201.00
D5860	Overdenture - complete, by report.	$493.00
D5861	Overdenture - partial, by report.	$571.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$493.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$571.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$493.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$571.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$28.00
D5411	Adjust complete denture - mandibular.	$26.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$29.00
D5422	Adjust partial denture - mandibular.	$28.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$64.00
D5660	Add clasp to existing partial denture.	$74.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$179.00
D5711	Rebase complete mandibular denture.	$190.00
D5720	Rebase maxillary partial denture.	$171.00
D5721	Rebase mandibular partial denture.	$181.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$50.00
D5851	Tissue conditioning, mandibular.	$54.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$411.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$449.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$449.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$411.00
D6062	Abutment supported cast metal crown (high noble metal).	$449.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$449.00
D6064	Abutment supported cast metal crown (noble metal).	$486.00
D6065	Implant supported porcelain/ceramic crown.	$411.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$411.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$449.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$449.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$411.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$449.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$449.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$486.00
D6075	Implant supported retainer for ceramic FPD.	$411.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$449.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$449.00
D6094	Abutment supported crown - (titanium).	$449.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$449.00
D6205	Pontic - indirect resin based composite.	$370.00
D6210	Pontic - cast high noble metal.	$449.00
D6211	Pontic - cast predominantly base metal.	$449.00
D6212	Pontic - cast noble metal.	$486.00
D6214	Pontic - titanium.	$449.00
D6240	Pontic - porcelain fused to high noble metal.	$449.00
D6241	Pontic - porcelain fused to predominantly base metal.	$449.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$411.00
D6245	Pontic - porcelain/ceramic.	$411.00
D6250	Pontic - resin with high noble metal.	$449.00
D6251	Pontic - resin with predominantly base metal.	$411.00
D6252	Pontic - resin with noble metal.	$486.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$150.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$150.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$366.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$402.00
D6602	Inlay - cast high noble metal, two surfaces.	$329.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$362.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$284.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$313.00
D6606	Inlay - cast noble metal, two surfaces.	$299.00
D6607	Inlay - cast noble metal, three or more surfaces.	$329.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$396.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$435.00
D6610	Onlay - cast high noble metal, two surfaces.	$362.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$398.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$313.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$344.00
D6614	Onlay - cast noble metal, two surfaces.	$329.00
D6615	Onlay - cast noble metal, three or more surfaces.	$362.00
D6624	Inlay - titanium.	$362.00
D6634	Onlay - titanium.	$398.00
D6710	Crown - indirect resin based composite.	$370.00
D6720	Crown - resin with high noble metal.	$449.00
D6721	Crown - resin with predominantly base metal.	$233.00
D6722	Crown - resin with noble metal.	$374.00
D6740	Crown - porcelain/ceramic.	$411.00
D6750	Crown - porcelain fused to high noble metal.	$486.00
D6751	Crown - porcelain fused to predominantly base metal.	$449.00
D6752	Crown - porcelain fused to noble metal.	$411.00
D6780	Crown - 3/4 cast high noble metal.	$486.00
D6781	Crown - 3/4 cast predominantly base metal.	$449.00
D6782	Crown - 3/4 cast noble metal.	$411.00
D6783	Crown - 3/4 porcelain/ceramic.	$411.00
D6790	Crown - full cast high noble metal.	$449.00
D6791	Crown - full cast predominantly base metal.	$449.00
D6792	Crown - full cast noble metal.	$411.00
D6794	Crown - titanium.	$449.00
D6940	Stress breaker.	$124.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$135.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$135.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$72.00
D9973	External bleaching - per tooth.	$45.00
D9974	Internal bleaching - per tooth.	$54.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 2

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$28.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$22.00
D0150	Comprehensive oral evaluation - new or established patient.	$43.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$43.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$14.00
D0272	Bitewings - two films.	$26.00
D0273	Bitewings - three films.	$31.00
D0274	Bitewings - four films.	$40.00
D0277	Vertical bitewings - 7 to 8 films.	$60.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$60.00
D1120	Prophylaxis - child.	$42.00
D1203	Topical application of fluoride - child.	$23.00
D1204	Topical application of fluoride - adult.	$23.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$23.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT		
D1351	Sealant - per tooth.	$33.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).

TYPE 1 PROCEDURES

Maximum Covered Expense

- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$212.00
D1515	Space maintainer - fixed - bilateral.	$347.00
D1520	Space maintainer - removable - unilateral.	$332.00
D1525	Space maintainer - removable - bilateral.	$405.00
D1550	Re-cementation of space maintainer.	$43.00
D1555	Removal of fixed space maintainer.	$60.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$319.00
D8220	Fixed appliance therapy.	$319.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$35.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$35.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$71.00
D0330	Panoramic film.	$57.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$13.00
D0230	Intraoral - periapical each additional film.	$10.00
D0240	Intraoral - occlusal film.	$18.00
D0250	Extraoral - first film.	$23.00
D0260	Extraoral - each additional film.	$18.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$42.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$83.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$83.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$60.00
D2150	Amalgam - two surfaces, primary or permanent.	$76.00
D2160	Amalgam - three surfaces, primary or permanent.	$92.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$110.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$73.00
D2331	Resin-based composite - two surfaces, anterior.	$92.00
D2332	Resin-based composite - three surfaces, anterior.	$115.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$127.00
D2391	Resin-based composite - one surface, posterior.	$80.00
D2392	Resin-based composite - two surfaces, posterior.	$101.00
D2393	Resin-based composite - three surfaces, posterior.	$127.00
D2394	Resin-based composite - four or more surfaces, posterior.	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$60.00
D2420	Gold foil - two surfaces.	$76.00
D2430	Gold foil - three surfaces.	$92.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$155.00
D2930	Prefabricated stainless steel crown - primary tooth.	$130.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$138.00
D2932	Prefabricated resin crown.	$155.00
D2933	Prefabricated stainless steel crown with resin window.	$155.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$155.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$48.00
D2915	Recement cast or prefabricated post and core.	$24.00
D2920	Recement crown.	$47.00
D6092	Recement implant/abutment supported crown.	$47.00
D6093	Recement implant/abutment supported fixed partial denture.	$47.00
D6930	Recement fixed partial denture.	$65.00

SEDATIVE FILLING

D2940	Sedative filling.	$44.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$74.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$76.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$76.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$63.00
D5610	Repair resin denture base.	$75.00
D5620	Repair cast framework.	$89.00
D5630	Repair or replace broken clasp.	$93.00
D5640	Replace broken teeth - per tooth.	$67.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5731	Reline complete mandibular denture (chairside).	$139.00
D5740	Reline maxillary partial denture (chairside).	$125.00
D5741	Reline mandibular partial denture (chairside).	$126.00
D5750	Reline complete maxillary denture (laboratory).	$208.00
D5751	Reline complete mandibular denture (laboratory).	$204.00
D5760	Reline maxillary partial denture (laboratory).	$208.00
D5761	Reline mandibular partial denture (laboratory).	$209.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$67.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$67.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$129.00
D7220	Removal of impacted tooth - soft tissue.	$161.00
D7230	Removal of impacted tooth - partially bony.	$214.00
D7240	Removal of impacted tooth - completely bony.	$250.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$285.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$134.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$316.00
D7261	Primary closure of a sinus perforation.	$316.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$191.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$191.00
D7280	Surgical access of an unerupted tooth.	$296.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$213.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$89.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$111.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$56.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$141.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$71.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$204.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$507.00
D7410	Excision of benign lesion up to 1.25 cm.	$202.00
D7411	Excision of benign lesion greater than 1.25 cm.	$259.00
D7412	Excision of benign lesion, complicated.	$285.00
D7413	Excision of malignant lesion up to 1.25 cm.	$273.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$200.00
D7415	Excision of malignant lesion, complicated.	$220.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$273.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$200.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$61.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$180.00
D7472	Removal of torus palatinus.	$180.00
D7473	Removal of torus mandibularis.	$180.00
D7485	Surgical reduction of osseous tuberosity.	$293.00
D7490	Radical resection of maxilla or mandible.	$273.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$90.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$104.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$83.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$228.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$228.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$300.00
D7910	Suture of recent small wounds up to 5 cm.	$40.00
D7911	Complicated suture - up to 5 cm.	$45.00
D7912	Complicated suture - greater than 5 cm.	$65.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$217.00
D7963	Frenuloplasty.	$271.00
D7970	Excision of hyperplastic tissue - per arch.	$167.00
D7972	Surgical reduction of fibrous tuberosity.	$266.00
D7980	Sialolithotomy.	$250.00
D7983	Closure of salivary fistula.	$80.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$271.00
D7286	Biopsy of oral tissue - soft.	$146.00
D7287	Exfoliative cytological sample collection.	$73.00
D7288	Brush biopsy - transepithelial sample collection.	$73.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$50.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$192.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$63.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$127.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$31.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$51.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$35.00
D9440	Office visit - after regularly scheduled hours.	$62.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$38.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$48.00
D9952	Occlusal adjustment - complete.	$241.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$42.00
D2951	Pin retention - per tooth, in addition to restoration.	$23.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$73.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$248.00
D2520	Inlay - metallic - two surfaces.	$295.00
D2530	Inlay - metallic - three or more surfaces.	$318.00
D2610	Inlay - porcelain/ceramic - one surface.	$273.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$297.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$326.00
D2650	Inlay - resin-based composite - one surface.	$284.00
D2651	Inlay - resin-based composite - two surfaces.	$280.00
D2652	Inlay - resin-based composite - three or more surfaces.	$290.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$321.00
D2543	Onlay - metallic - three surfaces.	$358.00
D2544	Onlay - metallic - four or more surfaces.	$373.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$321.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$371.00
D2662	Onlay - resin-based composite - two surfaces.	$301.00
D2663	Onlay - resin-based composite - three surfaces.	$310.00
D2664	Onlay - resin-based composite - four or more surfaces.	$330.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$140.00
D2712	Crown - 3/4 resin-based composite (indirect).	$348.00
D2720	Crown - resin with high noble metal.	$358.00
D2721	Crown - resin with predominantly base metal.	$273.00
D2722	Crown - resin with noble metal.	$335.00
D2740	Crown - porcelain/ceramic substrate.	$387.00
D2750	Crown - porcelain fused to high noble metal.	$376.00
D2751	Crown - porcelain fused to predominantly base metal.	$323.00
D2752	Crown - porcelain fused to noble metal.	$346.00
D2780	Crown - 3/4 cast high noble metal.	$358.00
D2781	Crown - 3/4 cast predominantly base metal.	$311.00
D2782	Crown - 3/4 cast noble metal.	$325.00
D2783	Crown - 3/4 porcelain/ceramic.	$387.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$358.00
D2791	Crown - full cast predominantly base metal.	$311.00
D2792	Crown - full cast noble metal.	$325.00
D2794	Crown - titanium.	$358.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$78.00
D6973	Core build up for retainer, including any pins.	$78.00

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$124.00
D2954	Prefabricated post and core in addition to crown.	$103.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$63.00
D6980	Fixed partial denture repair, by report.	$70.00
D9120	Fixed partial denture sectioning.	$70.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$49.00
D3221	Pulpal debridement, primary and permanent teeth.	$49.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$74.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$66.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$57.00
D3333	Internal root repair of perforation defects.	$81.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$81.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$160.00
D3430	Retrograde filling - per root.	$63.00
D3450	Root amputation - per root.	$150.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$127.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$225.00
D3320	Endodontic therapy, bicuspid tooth.	$265.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$347.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$132.00
D3346	Retreatment of previous root canal therapy - anterior.	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$323.00
D3348	Retreatment of previous root canal therapy - molar.	$400.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$231.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$267.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$289.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$103.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$146.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$74.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$201.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$101.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$369.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$185.00
D4263	Bone replacement graft - first site in quadrant.	$120.00
D4264	Bone replacement graft - each additional site in quadrant.	$91.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$60.00
D4270	Pedicle soft tissue graft procedure.	$272.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$287.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$335.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$162.00
D4275	Soft tissue allograft.	$287.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$335.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 3 PROCEDURES

		Maximum Covered Expense
CROWN LENGTHENING		
D4249	Clinical crown lengthening - hard tissue.	$222.00
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$75.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$38.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$55.00

CHEMOTHERAPEUTIC AGENTS: D4381
- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$400.00
D5120	Complete denture - mandibular.	$388.00
D5130	Immediate denture - maxillary.	$434.00
D5140	Immediate denture - mandibular.	$420.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$288.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$334.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$288.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$334.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$248.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$288.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$334.00
D5810	Interim complete denture (maxillary).	$177.00
D5811	Interim complete denture (mandibular).	$187.00
D5820	Interim partial denture (maxillary).	$156.00
D5821	Interim partial denture (mandibular).	$163.00
D5860	Overdenture - complete, by report.	$400.00
D5861	Overdenture - partial, by report.	$464.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$400.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$464.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$400.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$464.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$22.00
D5411	Adjust complete denture - mandibular.	$21.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$24.00
D5422	Adjust partial denture - mandibular.	$22.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$52.00
D5660	Add clasp to existing partial denture.	$60.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$146.00
D5711	Rebase complete mandibular denture.	$154.00
D5720	Rebase maxillary partial denture.	$139.00
D5721	Rebase mandibular partial denture.	$147.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$41.00
D5851	Tissue conditioning, mandibular.	$44.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$334.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$365.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$365.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$334.00
D6062	Abutment supported cast metal crown (high noble metal).	$365.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$365.00
D6064	Abutment supported cast metal crown (noble metal).	$395.00
D6065	Implant supported porcelain/ceramic crown.	$334.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$334.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$365.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$365.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$334.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$365.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$365.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$395.00
D6075	Implant supported retainer for ceramic FPD.	$334.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$365.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$365.00
D6094	Abutment supported crown - (titanium).	$365.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$365.00
D6205	Pontic - indirect resin based composite.	$301.00
D6210	Pontic - cast high noble metal.	$365.00
D6211	Pontic - cast predominantly base metal.	$365.00
D6212	Pontic - cast noble metal.	$395.00
D6214	Pontic - titanium.	$365.00
D6240	Pontic - porcelain fused to high noble metal.	$365.00
D6241	Pontic - porcelain fused to predominantly base metal.	$365.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$334.00
D6245	Pontic - porcelain/ceramic.	$334.00
D6250	Pontic - resin with high noble metal.	$365.00
D6251	Pontic - resin with predominantly base metal.	$334.00
D6252	Pontic - resin with noble metal.	$395.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$122.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$122.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$297.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$327.00
D6602	Inlay - cast high noble metal, two surfaces.	$267.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$294.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$231.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$254.00
D6606	Inlay - cast noble metal, two surfaces.	$243.00
D6607	Inlay - cast noble metal, three or more surfaces.	$267.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$321.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$354.00
D6610	Onlay - cast high noble metal, two surfaces.	$294.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$323.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$254.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$279.00
D6614	Onlay - cast noble metal, two surfaces.	$267.00
D6615	Onlay - cast noble metal, three or more surfaces.	$294.00
D6624	Inlay - titanium.	$294.00
D6634	Onlay - titanium.	$323.00
D6710	Crown - indirect resin based composite.	$301.00
D6720	Crown - resin with high noble metal.	$365.00
D6721	Crown - resin with predominantly base metal.	$189.00
D6722	Crown - resin with noble metal.	$304.00
D6740	Crown - porcelain/ceramic.	$334.00
D6750	Crown - porcelain fused to high noble metal.	$395.00
D6751	Crown - porcelain fused to predominantly base metal.	$365.00
D6752	Crown - porcelain fused to noble metal.	$334.00
D6780	Crown - 3/4 cast high noble metal.	$395.00
D6781	Crown - 3/4 cast predominantly base metal.	$365.00
D6782	Crown - 3/4 cast noble metal.	$334.00
D6783	Crown - 3/4 porcelain/ceramic.	$334.00
D6790	Crown - full cast high noble metal.	$365.00
D6791	Crown - full cast predominantly base metal.	$365.00
D6792	Crown - full cast noble metal.	$334.00
D6794	Crown - titanium.	$365.00
D6940	Stress breaker.	$101.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$109.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$109.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$58.00
D9973	External bleaching - per tooth.	$36.00
D9974	Internal bleaching - per tooth.	$44.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 3

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT		
D1351	Sealant - per tooth.	$28.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).

TYPE 1 PROCEDURES

		Maximum Covered Expense
	• Benefits are considered for persons age 16 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only.	
SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$177.00
D1515	Space maintainer - fixed - bilateral.	$289.00
D1520	Space maintainer - removable - unilateral.	$277.00
D1525	Space maintainer - removable - bilateral.	$337.00
D1550	Re-cementation of space maintainer.	$36.00
D1555	Removal of fixed space maintainer.	$50.00
	SPACE MAINTAINER: D1510, D1515, D1520, D1525 • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.	
APPLIANCE THERAPY		
D8210	Removable appliance therapy.	$266.00
D8220	Fixed appliance therapy.	$266.00
	APPLIANCE THERAPY: D8210, D8220 • Coverage is limited to the correction of thumb-sucking.	

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$59.00
D0330	Panoramic film.	$47.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$11.00
D0230	Intraoral - periapical each additional film.	$8.00
D0240	Intraoral - occlusal film.	$15.00
D0250	Extraoral - first film.	$19.00
D0260	Extraoral - each additional film.	$15.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$107.00
D7220	Removal of impacted tooth - soft tissue.	$134.00
D7230	Removal of impacted tooth - partially bony.	$178.00
D7240	Removal of impacted tooth - completely bony.	$208.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$237.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$112.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$160.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$52.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$106.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$26.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$191.00
D2520	Inlay - metallic - two surfaces.	$227.00
D2530	Inlay - metallic - three or more surfaces.	$244.00
D2610	Inlay - porcelain/ceramic - one surface.	$210.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$229.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$250.00
D2650	Inlay - resin-based composite - one surface.	$218.00
D2651	Inlay - resin-based composite - two surfaces.	$215.00
D2652	Inlay - resin-based composite - three or more surfaces.	$223.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$247.00
D2543	Onlay - metallic - three surfaces.	$276.00
D2544	Onlay - metallic - four or more surfaces.	$287.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$247.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$277.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$285.00
D2662	Onlay - resin-based composite - two surfaces.	$232.00
D2663	Onlay - resin-based composite - three surfaces.	$239.00
D2664	Onlay - resin-based composite - four or more surfaces.	$254.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$108.00
D2712	Crown - 3/4 resin-based composite (indirect).	$268.00
D2720	Crown - resin with high noble metal.	$276.00
D2721	Crown - resin with predominantly base metal.	$210.00
D2722	Crown - resin with noble metal.	$258.00
D2740	Crown - porcelain/ceramic substrate.	$298.00
D2750	Crown - porcelain fused to high noble metal.	$289.00
D2751	Crown - porcelain fused to predominantly base metal.	$248.00
D2752	Crown - porcelain fused to noble metal.	$266.00
D2780	Crown - 3/4 cast high noble metal.	$275.00
D2781	Crown - 3/4 cast predominantly base metal.	$239.00
D2782	Crown - 3/4 cast noble metal.	$250.00
D2783	Crown - 3/4 porcelain/ceramic.	$298.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$275.00
D2791	Crown - full cast predominantly base metal.	$239.00
D2792	Crown - full cast noble metal.	$250.00
D2794	Crown - titanium.	$275.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$60.00
D6973	Core build up for retainer, including any pins.	$60.00

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$95.00
D2954	Prefabricated post and core in addition to crown.	$79.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$48.00
D6980	Fixed partial denture repair, by report.	$54.00
D9120	Fixed partial denture sectioning.	$54.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$38.00
D3221	Pulpal debridement, primary and permanent teeth.	$38.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$57.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$44.00
D3333	Internal root repair of perforation defects.	$62.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$62.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$42.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$123.00
D3430	Retrograde filling - per root.	$49.00
D3450	Root amputation - per root.	$115.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$98.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$173.00
D3320	Endodontic therapy, bicuspid tooth.	$204.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$267.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$102.00
D3346	Retreatment of previous root canal therapy - anterior.	$215.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$248.00
D3348	Retreatment of previous root canal therapy - molar.	$308.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$178.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$205.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$222.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$79.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$113.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$57.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$155.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$78.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$284.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$142.00
D4263	Bone replacement graft - first site in quadrant.	$93.00
D4264	Bone replacement graft - each additional site in quadrant.	$70.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$46.00
D4270	Pedicle soft tissue graft procedure.	$209.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$221.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$258.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$124.00
D4275	Soft tissue allograft.	$221.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$258.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 3 PROCEDURES

		Maximum Covered Expense
CROWN LENGTHENING		
D4249	Clinical crown lengthening - hard tissue.	$171.00
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$58.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$29.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$43.00

CHEMOTHERAPEUTIC AGENTS: D4381
- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$308.00
D5120	Complete denture - mandibular.	$299.00
D5130	Immediate denture - maxillary.	$334.00
D5140	Immediate denture - mandibular.	$323.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$222.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$257.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$222.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$257.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$191.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$222.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$257.00
D5810	Interim complete denture (maxillary).	$136.00
D5811	Interim complete denture (mandibular).	$143.00
D5820	Interim partial denture (maxillary).	$120.00
D5821	Interim partial denture (mandibular).	$126.00
D5860	Overdenture - complete, by report.	$308.00
D5861	Overdenture - partial, by report.	$357.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$308.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$357.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$308.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$357.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$17.00
D5411	Adjust complete denture - mandibular.	$16.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$18.00
D5422	Adjust partial denture - mandibular.	$17.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$40.00
D5660	Add clasp to existing partial denture.	$46.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$112.00
D5711	Rebase complete mandibular denture.	$119.00
D5720	Rebase maxillary partial denture.	$107.00
D5721	Rebase mandibular partial denture.	$113.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$31.00
D5851	Tissue conditioning, mandibular.	$34.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$257.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$280.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$280.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$257.00
D6062	Abutment supported cast metal crown (high noble metal).	$280.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$280.00
D6064	Abutment supported cast metal crown (noble metal).	$304.00
D6065	Implant supported porcelain/ceramic crown.	$257.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$257.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$280.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$280.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$257.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$280.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$280.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$304.00
D6075	Implant supported retainer for ceramic FPD.	$257.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$280.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$280.00
D6094	Abutment supported crown - (titanium).	$280.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$280.00
D6205	Pontic - indirect resin based composite.	$231.00
D6210	Pontic - cast high noble metal.	$280.00
D6211	Pontic - cast predominantly base metal.	$280.00
D6212	Pontic - cast noble metal.	$304.00
D6214	Pontic - titanium.	$280.00
D6240	Pontic - porcelain fused to high noble metal.	$280.00
D6241	Pontic - porcelain fused to predominantly base metal.	$280.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$257.00
D6245	Pontic - porcelain/ceramic.	$257.00
D6250	Pontic - resin with high noble metal.	$280.00
D6251	Pontic - resin with predominantly base metal.	$257.00
D6252	Pontic - resin with noble metal.	$304.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$93.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$93.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$229.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$251.00
D6602	Inlay - cast high noble metal, two surfaces.	$206.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$226.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$178.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$195.00
D6606	Inlay - cast noble metal, two surfaces.	$187.00
D6607	Inlay - cast noble metal, three or more surfaces.	$206.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$247.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$272.00
D6610	Onlay - cast high noble metal, two surfaces.	$226.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$249.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$195.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$215.00
D6614	Onlay - cast noble metal, two surfaces.	$206.00
D6615	Onlay - cast noble metal, three or more surfaces.	$226.00
D6624	Inlay - titanium.	$226.00
D6634	Onlay - titanium.	$249.00
D6710	Crown - indirect resin based composite.	$231.00
D6720	Crown - resin with high noble metal.	$280.00
D6721	Crown - resin with predominantly base metal.	$145.00
D6722	Crown - resin with noble metal.	$234.00
D6740	Crown - porcelain/ceramic.	$257.00
D6750	Crown - porcelain fused to high noble metal.	$304.00
D6751	Crown - porcelain fused to predominantly base metal.	$280.00
D6752	Crown - porcelain fused to noble metal.	$257.00
D6780	Crown - 3/4 cast high noble metal.	$304.00
D6781	Crown - 3/4 cast predominantly base metal.	$280.00
D6782	Crown - 3/4 cast noble metal.	$257.00
D6783	Crown - 3/4 porcelain/ceramic.	$257.00
D6790	Crown - full cast high noble metal.	$280.00
D6791	Crown - full cast predominantly base metal.	$280.00
D6792	Crown - full cast noble metal.	$257.00
D6794	Crown - titanium.	$280.00
D6940	Stress breaker.	$78.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$84.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$84.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$45.00
D9973	External bleaching - per tooth.	$28.00
D9974	Internal bleaching - per tooth.	$34.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 4

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180
- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145
- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$76.00
D0330	Panoramic film.	$61.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330
- Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$14.00
D0230	Intraoral - periapical each additional film.	$11.00
D0240	Intraoral - occlusal film.	$19.00
D0250	Extraoral - first film.	$24.00
D0260	Extraoral - each additional film.	$19.00

PERIAPICAL FILMS: D0220, D0230
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274
- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277
- Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

SEALANT		
D1351	Sealant - per tooth.	$22.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 2 PROCEDURES

		Maximum Covered Expense
	GOLD FOIL RESTORATIONS: D2410, D2420, D2430	
	• Gold foils are considered at an alternate benefit of an amalgam/composite restoration.	
	STAINLESS STEEL CROWN (PREFABRICATED CROWN)	
D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00
	STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934	
	• Replacement is limited to 1 of any of these procedures per 12 month(s).	
	• Porcelain and resin benefits are considered for anterior and bicuspid teeth only.	
	RECEMENT	
D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00
	SEDATIVE FILLING	
D2940	Sedative filling.	$37.00
	ENDODONTICS MISCELLANEOUS	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$67.00
D3221	Pulpal debridement, primary and permanent teeth.	$67.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$102.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$90.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$78.00
D3333	Internal root repair of perforation defects.	$111.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$111.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$75.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$219.00
D3430	Retrograde filling - per root.	$87.00
D3450	Root amputation - per root.	$206.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$174.00
	ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920	
	• Procedure D3333 is limited to permanent teeth only.	
	ENDODONTIC THERAPY (ROOT CANALS)	
D3310	Endodontic therapy, anterior tooth.	$308.00
D3320	Endodontic therapy, bicuspid tooth.	$363.00
D3330	Endodontic therapy, molar.	$476.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$182.00
D3346	Retreatment of previous root canal therapy - anterior.	$384.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D3347	Retreatment of previous root canal therapy - bicuspid.	$442.00
D3348	Retreatment of previous root canal therapy - molar.	$549.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

Class Number 5

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$33.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$25.00
D0150	Comprehensive oral evaluation - new or established patient.	$50.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$50.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$16.00
D0272	Bitewings - two films.	$30.00
D0273	Bitewings - three films.	$36.00
D0274	Bitewings - four films.	$46.00
D0277	Vertical bitewings - 7 to 8 films.	$70.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$70.00
D1120	Prophylaxis - child.	$49.00
D1203	Topical application of fluoride - child.	$27.00
D1204	Topical application of fluoride - adult.	$27.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$27.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT		
D1351	Sealant - per tooth.	$38.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).

TYPE 1 PROCEDURES

		Maximum Covered Expense
	• Benefits are considered for persons age 16 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only.	
SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$246.00
D1515	Space maintainer - fixed - bilateral.	$402.00
D1520	Space maintainer - removable - unilateral.	$385.00
D1525	Space maintainer - removable - bilateral.	$469.00
D1550	Re-cementation of space maintainer.	$50.00
D1555	Removal of fixed space maintainer.	$70.00
	SPACE MAINTAINER: D1510, D1515, D1520, D1525 • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.	
APPLIANCE THERAPY		
D8210	Removable appliance therapy.	$370.00
D8220	Fixed appliance therapy.	$370.00
	APPLIANCE THERAPY: D8210, D8220 • Coverage is limited to the correction of thumb-sucking.	

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$41.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$41.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$83.00
D0330	Panoramic film.	$67.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$15.00
D0230	Intraoral - periapical each additional film.	$12.00
D0240	Intraoral - occlusal film.	$21.00
D0250	Extraoral - first film.	$27.00
D0260	Extraoral - each additional film.	$21.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$49.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$97.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$97.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$70.00
D2150	Amalgam - two surfaces, primary or permanent.	$89.00
D2160	Amalgam - three surfaces, primary or permanent.	$107.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$128.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$85.00
D2331	Resin-based composite - two surfaces, anterior.	$107.00
D2332	Resin-based composite - three surfaces, anterior.	$134.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$148.00
D2391	Resin-based composite - one surface, posterior.	$93.00
D2392	Resin-based composite - two surfaces, posterior.	$118.00
D2393	Resin-based composite - three surfaces, posterior.	$148.00
D2394	Resin-based composite - four or more surfaces, posterior.	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$70.00
D2420	Gold foil - two surfaces.	$89.00
D2430	Gold foil - three surfaces.	$107.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$181.00
D2930	Prefabricated stainless steel crown - primary tooth.	$152.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$161.00
D2932	Prefabricated resin crown.	$181.00
D2933	Prefabricated stainless steel crown with resin window.	$181.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$181.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$56.00
D2915	Recement cast or prefabricated post and core.	$28.00
D2920	Recement crown.	$55.00
D6092	Recement implant/abutment supported crown.	$55.00
D6093	Recement implant/abutment supported fixed partial denture.	$55.00
D6930	Recement fixed partial denture.	$76.00

SEDATIVE FILLING

D2940	Sedative filling.	$51.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$86.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$89.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$89.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$74.00
D5610	Repair resin denture base.	$88.00
D5620	Repair cast framework.	$104.00
D5630	Repair or replace broken clasp.	$109.00
D5640	Replace broken teeth - per tooth.	$78.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5731	Reline complete mandibular denture (chairside).	$162.00
D5740	Reline maxillary partial denture (chairside).	$146.00
D5741	Reline mandibular partial denture (chairside).	$147.00
D5750	Reline complete maxillary denture (laboratory).	$243.00
D5751	Reline complete mandibular denture (laboratory).	$238.00
D5760	Reline maxillary partial denture (laboratory).	$243.00
D5761	Reline mandibular partial denture (laboratory).	$244.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$78.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$78.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$151.00
D7220	Removal of impacted tooth - soft tissue.	$188.00
D7230	Removal of impacted tooth - partially bony.	$250.00
D7240	Removal of impacted tooth - completely bony.	$292.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$333.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$156.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$369.00
D7261	Primary closure of a sinus perforation.	$369.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$223.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$223.00
D7280	Surgical access of an unerupted tooth.	$345.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$249.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$104.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$130.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$65.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$165.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$83.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$238.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$592.00
D7410	Excision of benign lesion up to 1.25 cm.	$236.00
D7411	Excision of benign lesion greater than 1.25 cm.	$302.00
D7412	Excision of benign lesion, complicated.	$333.00
D7413	Excision of malignant lesion up to 1.25 cm.	$319.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$233.00
D7415	Excision of malignant lesion, complicated.	$257.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$319.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$233.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$71.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$210.00
D7472	Removal of torus palatinus.	$210.00
D7473	Removal of torus mandibularis.	$210.00
D7485	Surgical reduction of osseous tuberosity.	$342.00
D7490	Radical resection of maxilla or mandible.	$319.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$105.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$121.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$97.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$266.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$266.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$350.00
D7910	Suture of recent small wounds up to 5 cm.	$47.00
D7911	Complicated suture - up to 5 cm.	$53.00
D7912	Complicated suture - greater than 5 cm.	$76.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$253.00
D7963	Frenuloplasty.	$316.00
D7970	Excision of hyperplastic tissue - per arch.	$195.00
D7972	Surgical reduction of fibrous tuberosity.	$310.00
D7980	Sialolithotomy.	$292.00
D7983	Closure of salivary fistula.	$93.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$316.00
D7286	Biopsy of oral tissue - soft.	$170.00
D7287	Exfoliative cytological sample collection.	$85.00
D7288	Brush biopsy - transepithelial sample collection.	$85.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$58.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$224.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$74.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$148.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$36.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$60.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$41.00
D9440	Office visit - after regularly scheduled hours.	$72.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$44.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$56.00
D9952	Occlusal adjustment - complete.	$281.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$49.00
D2951	Pin retention - per tooth, in addition to restoration.	$27.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$85.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$305.00
D2520	Inlay - metallic - two surfaces.	$363.00
D2530	Inlay - metallic - three or more surfaces.	$391.00
D2610	Inlay - porcelain/ceramic - one surface.	$336.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$366.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$401.00
D2650	Inlay - resin-based composite - one surface.	$349.00
D2651	Inlay - resin-based composite - two surfaces.	$345.00
D2652	Inlay - resin-based composite - three or more surfaces.	$357.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$396.00
D2543	Onlay - metallic - three surfaces.	$441.00
D2544	Onlay - metallic - four or more surfaces.	$459.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$396.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$443.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$456.00
D2662	Onlay - resin-based composite - two surfaces.	$371.00
D2663	Onlay - resin-based composite - three surfaces.	$382.00
D2664	Onlay - resin-based composite - four or more surfaces.	$406.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$173.00
D2712	Crown - 3/4 resin-based composite (indirect).	$428.00
D2720	Crown - resin with high noble metal.	$441.00
D2721	Crown - resin with predominantly base metal.	$336.00
D2722	Crown - resin with noble metal.	$413.00
D2740	Crown - porcelain/ceramic substrate.	$476.00
D2750	Crown - porcelain fused to high noble metal.	$463.00
D2751	Crown - porcelain fused to predominantly base metal.	$397.00
D2752	Crown - porcelain fused to noble metal.	$425.00
D2780	Crown - 3/4 cast high noble metal.	$440.00
D2781	Crown - 3/4 cast predominantly base metal.	$383.00
D2782	Crown - 3/4 cast noble metal.	$400.00
D2783	Crown - 3/4 porcelain/ceramic.	$476.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$440.00
D2791	Crown - full cast predominantly base metal.	$383.00
D2792	Crown - full cast noble metal.	$400.00
D2794	Crown - titanium.	$440.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$96.00
D6973	Core build up for retainer, including any pins.	$96.00

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$153.00
D2954	Prefabricated post and core in addition to crown.	$127.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$77.00
D6980	Fixed partial denture repair, by report.	$86.00
D9120	Fixed partial denture sectioning.	$86.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$61.00
D3221	Pulpal debridement, primary and permanent teeth.	$61.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$91.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$81.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$70.00
D3333	Internal root repair of perforation defects.	$99.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$99.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$67.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$197.00
D3430	Retrograde filling - per root.	$78.00
D3450	Root amputation - per root.	$185.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$156.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$277.00
D3320	Endodontic therapy, bicuspid tooth.	$326.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$427.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$163.00
D3346	Retreatment of previous root canal therapy - anterior.	$345.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$397.00
D3348	Retreatment of previous root canal therapy - molar.	$493.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$285.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$328.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$355.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$127.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$180.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$90.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$247.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$124.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$454.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$227.00
D4263	Bone replacement graft - first site in quadrant.	$148.00
D4264	Bone replacement graft - each additional site in quadrant.	$111.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$74.00
D4270	Pedicle soft tissue graft procedure.	$334.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$354.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$413.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$199.00
D4275	Soft tissue allograft.	$354.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$413.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 3 PROCEDURES

		Maximum Covered Expense
CROWN LENGTHENING		
D4249	Clinical crown lengthening - hard tissue.	$273.00
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$93.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$46.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$68.00

CHEMOTHERAPEUTIC AGENTS: D4381
- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$493.00
D5120	Complete denture - mandibular.	$478.00
D5130	Immediate denture - maxillary.	$534.00
D5140	Immediate denture - mandibular.	$517.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$354.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$354.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$410.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$306.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$354.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$410.00
D5810	Interim complete denture (maxillary).	$218.00
D5811	Interim complete denture (mandibular).	$230.00
D5820	Interim partial denture (maxillary).	$191.00
D5821	Interim partial denture (mandibular).	$201.00
D5860	Overdenture - complete, by report.	$493.00
D5861	Overdenture - partial, by report.	$571.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$493.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$571.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$493.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$571.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$28.00
D5411	Adjust complete denture - mandibular.	$26.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$29.00
D5422	Adjust partial denture - mandibular.	$28.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$64.00
D5660	Add clasp to existing partial denture.	$74.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$179.00
D5711	Rebase complete mandibular denture.	$190.00
D5720	Rebase maxillary partial denture.	$171.00
D5721	Rebase mandibular partial denture.	$181.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$50.00
D5851	Tissue conditioning, mandibular.	$54.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$411.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$449.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$449.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$411.00
D6062	Abutment supported cast metal crown (high noble metal).	$449.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$449.00
D6064	Abutment supported cast metal crown (noble metal).	$486.00
D6065	Implant supported porcelain/ceramic crown.	$411.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$411.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$449.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$449.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$411.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$449.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$449.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$486.00
D6075	Implant supported retainer for ceramic FPD.	$411.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$449.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$449.00
D6094	Abutment supported crown - (titanium).	$449.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$449.00
D6205	Pontic - indirect resin based composite.	$370.00
D6210	Pontic - cast high noble metal.	$449.00
D6211	Pontic - cast predominantly base metal.	$449.00
D6212	Pontic - cast noble metal.	$486.00
D6214	Pontic - titanium.	$449.00
D6240	Pontic - porcelain fused to high noble metal.	$449.00
D6241	Pontic - porcelain fused to predominantly base metal.	$449.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$411.00
D6245	Pontic - porcelain/ceramic.	$411.00
D6250	Pontic - resin with high noble metal.	$449.00
D6251	Pontic - resin with predominantly base metal.	$411.00
D6252	Pontic - resin with noble metal.	$486.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$150.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$150.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$366.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$402.00
D6602	Inlay - cast high noble metal, two surfaces.	$329.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$362.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$284.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$313.00
D6606	Inlay - cast noble metal, two surfaces.	$299.00
D6607	Inlay - cast noble metal, three or more surfaces.	$329.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$396.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$435.00
D6610	Onlay - cast high noble metal, two surfaces.	$362.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$398.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$313.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$344.00
D6614	Onlay - cast noble metal, two surfaces.	$329.00
D6615	Onlay - cast noble metal, three or more surfaces.	$362.00
D6624	Inlay - titanium.	$362.00
D6634	Onlay - titanium.	$398.00
D6710	Crown - indirect resin based composite.	$370.00
D6720	Crown - resin with high noble metal.	$449.00
D6721	Crown - resin with predominantly base metal.	$233.00
D6722	Crown - resin with noble metal.	$374.00
D6740	Crown - porcelain/ceramic.	$411.00
D6750	Crown - porcelain fused to high noble metal.	$486.00
D6751	Crown - porcelain fused to predominantly base metal.	$449.00
D6752	Crown - porcelain fused to noble metal.	$411.00
D6780	Crown - 3/4 cast high noble metal.	$486.00
D6781	Crown - 3/4 cast predominantly base metal.	$449.00
D6782	Crown - 3/4 cast noble metal.	$411.00
D6783	Crown - 3/4 porcelain/ceramic.	$411.00
D6790	Crown - full cast high noble metal.	$449.00
D6791	Crown - full cast predominantly base metal.	$449.00
D6792	Crown - full cast noble metal.	$411.00
D6794	Crown - titanium.	$449.00
D6940	Stress breaker.	$124.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$135.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$135.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$72.00
D9973	External bleaching - per tooth.	$45.00
D9974	Internal bleaching - per tooth.	$54.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 6

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$28.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$22.00
D0150	Comprehensive oral evaluation - new or established patient.	$43.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$43.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$14.00
D0272	Bitewings - two films.	$26.00
D0273	Bitewings - three films.	$31.00
D0274	Bitewings - four films.	$40.00
D0277	Vertical bitewings - 7 to 8 films.	$60.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$60.00
D1120	Prophylaxis - child.	$42.00
D1203	Topical application of fluoride - child.	$23.00
D1204	Topical application of fluoride - adult.	$23.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$23.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT		
D1351	Sealant - per tooth.	$33.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).

TYPE 1 PROCEDURES

Maximum Covered Expense

- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$212.00
D1515	Space maintainer - fixed - bilateral.	$347.00
D1520	Space maintainer - removable - unilateral.	$332.00
D1525	Space maintainer - removable - bilateral.	$405.00
D1550	Re-cementation of space maintainer.	$43.00
D1555	Removal of fixed space maintainer.	$60.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$319.00
D8220	Fixed appliance therapy.	$319.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$35.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$35.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$71.00
D0330	Panoramic film.	$57.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$13.00
D0230	Intraoral - periapical each additional film.	$10.00
D0240	Intraoral - occlusal film.	$18.00
D0250	Extraoral - first film.	$23.00
D0260	Extraoral - each additional film.	$18.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$42.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$83.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$83.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$60.00
D2150	Amalgam - two surfaces, primary or permanent.	$76.00
D2160	Amalgam - three surfaces, primary or permanent.	$92.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$110.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$73.00
D2331	Resin-based composite - two surfaces, anterior.	$92.00
D2332	Resin-based composite - three surfaces, anterior.	$115.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$127.00
D2391	Resin-based composite - one surface, posterior.	$80.00
D2392	Resin-based composite - two surfaces, posterior.	$101.00
D2393	Resin-based composite - three surfaces, posterior.	$127.00
D2394	Resin-based composite - four or more surfaces, posterior.	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$60.00
D2420	Gold foil - two surfaces.	$76.00
D2430	Gold foil - three surfaces.	$92.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$155.00
D2930	Prefabricated stainless steel crown - primary tooth.	$130.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$138.00
D2932	Prefabricated resin crown.	$155.00
D2933	Prefabricated stainless steel crown with resin window.	$155.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$155.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$48.00
D2915	Recement cast or prefabricated post and core.	$24.00
D2920	Recement crown.	$47.00
D6092	Recement implant/abutment supported crown.	$47.00
D6093	Recement implant/abutment supported fixed partial denture.	$47.00
D6930	Recement fixed partial denture.	$65.00

SEDATIVE FILLING

D2940	Sedative filling.	$44.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$74.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$76.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$76.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$63.00
D5610	Repair resin denture base.	$75.00
D5620	Repair cast framework.	$89.00
D5630	Repair or replace broken clasp.	$93.00
D5640	Replace broken teeth - per tooth.	$67.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5731	Reline complete mandibular denture (chairside).	$139.00
D5740	Reline maxillary partial denture (chairside).	$125.00
D5741	Reline mandibular partial denture (chairside).	$126.00
D5750	Reline complete maxillary denture (laboratory).	$208.00
D5751	Reline complete mandibular denture (laboratory).	$204.00
D5760	Reline maxillary partial denture (laboratory).	$208.00
D5761	Reline mandibular partial denture (laboratory).	$209.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$67.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$67.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$129.00
D7220	Removal of impacted tooth - soft tissue.	$161.00
D7230	Removal of impacted tooth - partially bony.	$214.00
D7240	Removal of impacted tooth - completely bony.	$250.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$285.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$134.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$316.00
D7261	Primary closure of a sinus perforation.	$316.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$191.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$191.00
D7280	Surgical access of an unerupted tooth.	$296.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$213.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$89.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$111.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$56.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$141.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$71.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$204.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$507.00
D7410	Excision of benign lesion up to 1.25 cm.	$202.00
D7411	Excision of benign lesion greater than 1.25 cm.	$259.00
D7412	Excision of benign lesion, complicated.	$285.00
D7413	Excision of malignant lesion up to 1.25 cm.	$273.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$200.00
D7415	Excision of malignant lesion, complicated.	$220.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$273.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$200.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$61.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$180.00
D7472	Removal of torus palatinus.	$180.00
D7473	Removal of torus mandibularis.	$180.00
D7485	Surgical reduction of osseous tuberosity.	$293.00
D7490	Radical resection of maxilla or mandible.	$273.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$90.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$104.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$83.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$228.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$228.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$300.00
D7910	Suture of recent small wounds up to 5 cm.	$40.00
D7911	Complicated suture - up to 5 cm.	$45.00
D7912	Complicated suture - greater than 5 cm.	$65.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$217.00
D7963	Frenuloplasty.	$271.00
D7970	Excision of hyperplastic tissue - per arch.	$167.00
D7972	Surgical reduction of fibrous tuberosity.	$266.00
D7980	Sialolithotomy.	$250.00
D7983	Closure of salivary fistula.	$80.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$271.00
D7286	Biopsy of oral tissue - soft.	$146.00
D7287	Exfoliative cytological sample collection.	$73.00
D7288	Brush biopsy - transepithelial sample collection.	$73.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$50.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$192.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$63.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$127.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$31.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$51.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$35.00
D9440	Office visit - after regularly scheduled hours.	$62.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$38.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$48.00
D9952	Occlusal adjustment - complete.	$241.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$42.00
D2951	Pin retention - per tooth, in addition to restoration.	$23.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$73.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$248.00
D2520	Inlay - metallic - two surfaces.	$295.00
D2530	Inlay - metallic - three or more surfaces.	$318.00
D2610	Inlay - porcelain/ceramic - one surface.	$273.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$297.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$326.00
D2650	Inlay - resin-based composite - one surface.	$284.00
D2651	Inlay - resin-based composite - two surfaces.	$280.00
D2652	Inlay - resin-based composite - three or more surfaces.	$290.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$321.00
D2543	Onlay - metallic - three surfaces.	$358.00
D2544	Onlay - metallic - four or more surfaces.	$373.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$321.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$371.00
D2662	Onlay - resin-based composite - two surfaces.	$301.00
D2663	Onlay - resin-based composite - three surfaces.	$310.00
D2664	Onlay - resin-based composite - four or more surfaces.	$330.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$140.00
D2712	Crown - 3/4 resin-based composite (indirect).	$348.00
D2720	Crown - resin with high noble metal.	$358.00
D2721	Crown - resin with predominantly base metal.	$273.00
D2722	Crown - resin with noble metal.	$335.00
D2740	Crown - porcelain/ceramic substrate.	$387.00
D2750	Crown - porcelain fused to high noble metal.	$376.00
D2751	Crown - porcelain fused to predominantly base metal.	$323.00
D2752	Crown - porcelain fused to noble metal.	$346.00
D2780	Crown - 3/4 cast high noble metal.	$358.00
D2781	Crown - 3/4 cast predominantly base metal.	$311.00
D2782	Crown - 3/4 cast noble metal.	$325.00
D2783	Crown - 3/4 porcelain/ceramic.	$387.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$358.00
D2791	Crown - full cast predominantly base metal.	$311.00
D2792	Crown - full cast noble metal.	$325.00
D2794	Crown - titanium.	$358.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$78.00
D6973	Core build up for retainer, including any pins.	$78.00

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$124.00
D2954	Prefabricated post and core in addition to crown.	$103.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$63.00
D6980	Fixed partial denture repair, by report.	$70.00
D9120	Fixed partial denture sectioning.	$70.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$49.00
D3221	Pulpal debridement, primary and permanent teeth.	$49.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$74.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$66.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$57.00
D3333	Internal root repair of perforation defects.	$81.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$81.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$160.00
D3430	Retrograde filling - per root.	$63.00
D3450	Root amputation - per root.	$150.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$127.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$225.00
D3320	Endodontic therapy, bicuspid tooth.	$265.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$347.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$132.00
D3346	Retreatment of previous root canal therapy - anterior.	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$323.00
D3348	Retreatment of previous root canal therapy - molar.	$400.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$231.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$267.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$289.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$103.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$146.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$74.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$201.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$101.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$369.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$185.00
D4263	Bone replacement graft - first site in quadrant.	$120.00
D4264	Bone replacement graft - each additional site in quadrant.	$91.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$60.00
D4270	Pedicle soft tissue graft procedure.	$272.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$287.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$335.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$162.00
D4275	Soft tissue allograft.	$287.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$335.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 3 PROCEDURES

		Maximum Covered Expense
CROWN LENGTHENING		
D4249	Clinical crown lengthening - hard tissue.	$222.00
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$75.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$38.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$55.00

CHEMOTHERAPEUTIC AGENTS: D4381
- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$400.00
D5120	Complete denture - mandibular.	$388.00
D5130	Immediate denture - maxillary.	$434.00
D5140	Immediate denture - mandibular.	$420.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$288.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$334.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$288.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$334.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$248.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$288.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$334.00
D5810	Interim complete denture (maxillary).	$177.00
D5811	Interim complete denture (mandibular).	$187.00
D5820	Interim partial denture (maxillary).	$156.00
D5821	Interim partial denture (mandibular).	$163.00
D5860	Overdenture - complete, by report.	$400.00
D5861	Overdenture - partial, by report.	$464.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$400.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$464.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$400.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$464.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$22.00
D5411	Adjust complete denture - mandibular.	$21.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$24.00
D5422	Adjust partial denture - mandibular.	$22.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$52.00
D5660	Add clasp to existing partial denture.	$60.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$146.00
D5711	Rebase complete mandibular denture.	$154.00
D5720	Rebase maxillary partial denture.	$139.00
D5721	Rebase mandibular partial denture.	$147.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$41.00
D5851	Tissue conditioning, mandibular.	$44.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$334.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$365.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$365.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$334.00
D6062	Abutment supported cast metal crown (high noble metal).	$365.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$365.00
D6064	Abutment supported cast metal crown (noble metal).	$395.00
D6065	Implant supported porcelain/ceramic crown.	$334.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$334.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$365.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$365.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$334.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$365.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$365.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$395.00
D6075	Implant supported retainer for ceramic FPD.	$334.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$365.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$365.00
D6094	Abutment supported crown - (titanium).	$365.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$365.00
D6205	Pontic - indirect resin based composite.	$301.00
D6210	Pontic - cast high noble metal.	$365.00
D6211	Pontic - cast predominantly base metal.	$365.00
D6212	Pontic - cast noble metal.	$395.00
D6214	Pontic - titanium.	$365.00
D6240	Pontic - porcelain fused to high noble metal.	$365.00
D6241	Pontic - porcelain fused to predominantly base metal.	$365.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$334.00
D6245	Pontic - porcelain/ceramic.	$334.00
D6250	Pontic - resin with high noble metal.	$365.00
D6251	Pontic - resin with predominantly base metal.	$334.00
D6252	Pontic - resin with noble metal.	$395.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$122.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$122.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$297.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$327.00
D6602	Inlay - cast high noble metal, two surfaces.	$267.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$294.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$231.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$254.00
D6606	Inlay - cast noble metal, two surfaces.	$243.00
D6607	Inlay - cast noble metal, three or more surfaces.	$267.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$321.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$354.00
D6610	Onlay - cast high noble metal, two surfaces.	$294.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$323.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$254.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$279.00
D6614	Onlay - cast noble metal, two surfaces.	$267.00
D6615	Onlay - cast noble metal, three or more surfaces.	$294.00
D6624	Inlay - titanium.	$294.00
D6634	Onlay - titanium.	$323.00
D6710	Crown - indirect resin based composite.	$301.00
D6720	Crown - resin with high noble metal.	$365.00
D6721	Crown - resin with predominantly base metal.	$189.00
D6722	Crown - resin with noble metal.	$304.00
D6740	Crown - porcelain/ceramic.	$334.00
D6750	Crown - porcelain fused to high noble metal.	$395.00
D6751	Crown - porcelain fused to predominantly base metal.	$365.00
D6752	Crown - porcelain fused to noble metal.	$334.00
D6780	Crown - 3/4 cast high noble metal.	$395.00
D6781	Crown - 3/4 cast predominantly base metal.	$365.00
D6782	Crown - 3/4 cast noble metal.	$334.00
D6783	Crown - 3/4 porcelain/ceramic.	$334.00
D6790	Crown - full cast high noble metal.	$365.00
D6791	Crown - full cast predominantly base metal.	$365.00
D6792	Crown - full cast noble metal.	$334.00
D6794	Crown - titanium.	$365.00
D6940	Stress breaker.	$101.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$109.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$109.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$58.00
D9973	External bleaching - per tooth.	$36.00
D9974	Internal bleaching - per tooth.	$44.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 7

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT		
D1351	Sealant - per tooth.	$28.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).

TYPE 1 PROCEDURES

		Maximum Covered Expense
	• Benefits are considered for persons age 16 and under. • Benefits are considered on permanent molars only. • Coverage is allowed on the occlusal surface only.	
SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$177.00
D1515	Space maintainer - fixed - bilateral.	$289.00
D1520	Space maintainer - removable - unilateral.	$277.00
D1525	Space maintainer - removable - bilateral.	$337.00
D1550	Re-cementation of space maintainer.	$36.00
D1555	Removal of fixed space maintainer.	$50.00
	SPACE MAINTAINER: D1510, D1515, D1520, D1525 • Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.	
APPLIANCE THERAPY		
D8210	Removable appliance therapy.	$266.00
D8220	Fixed appliance therapy.	$266.00
	APPLIANCE THERAPY: D8210, D8220 • Coverage is limited to the correction of thumb-sucking.	

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$59.00
D0330	Panoramic film.	$47.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$11.00
D0230	Intraoral - periapical each additional film.	$8.00
D0240	Intraoral - occlusal film.	$15.00
D0250	Extraoral - first film.	$19.00
D0260	Extraoral - each additional film.	$15.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$107.00
D7220	Removal of impacted tooth - soft tissue.	$134.00
D7230	Removal of impacted tooth - partially bony.	$178.00
D7240	Removal of impacted tooth - completely bony.	$208.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$237.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$112.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$160.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$52.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$106.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$26.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$191.00
D2520	Inlay - metallic - two surfaces.	$227.00
D2530	Inlay - metallic - three or more surfaces.	$244.00
D2610	Inlay - porcelain/ceramic - one surface.	$210.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$229.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$250.00
D2650	Inlay - resin-based composite - one surface.	$218.00
D2651	Inlay - resin-based composite - two surfaces.	$215.00
D2652	Inlay - resin-based composite - three or more surfaces.	$223.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$247.00
D2543	Onlay - metallic - three surfaces.	$276.00
D2544	Onlay - metallic - four or more surfaces.	$287.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$247.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$277.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$285.00
D2662	Onlay - resin-based composite - two surfaces.	$232.00
D2663	Onlay - resin-based composite - three surfaces.	$239.00
D2664	Onlay - resin-based composite - four or more surfaces.	$254.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$108.00
D2712	Crown - 3/4 resin-based composite (indirect).	$268.00
D2720	Crown - resin with high noble metal.	$276.00
D2721	Crown - resin with predominantly base metal.	$210.00
D2722	Crown - resin with noble metal.	$258.00
D2740	Crown - porcelain/ceramic substrate.	$298.00
D2750	Crown - porcelain fused to high noble metal.	$289.00
D2751	Crown - porcelain fused to predominantly base metal.	$248.00
D2752	Crown - porcelain fused to noble metal.	$266.00
D2780	Crown - 3/4 cast high noble metal.	$275.00
D2781	Crown - 3/4 cast predominantly base metal.	$239.00
D2782	Crown - 3/4 cast noble metal.	$250.00
D2783	Crown - 3/4 porcelain/ceramic.	$298.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$275.00
D2791	Crown - full cast predominantly base metal.	$239.00
D2792	Crown - full cast noble metal.	$250.00
D2794	Crown - titanium.	$275.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$60.00
D6973	Core build up for retainer, including any pins.	$60.00

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$95.00
D2954	Prefabricated post and core in addition to crown.	$79.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$48.00
D6980	Fixed partial denture repair, by report.	$54.00
D9120	Fixed partial denture sectioning.	$54.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$38.00
D3221	Pulpal debridement, primary and permanent teeth.	$38.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$57.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$44.00
D3333	Internal root repair of perforation defects.	$62.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$62.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$42.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$123.00
D3430	Retrograde filling - per root.	$49.00
D3450	Root amputation - per root.	$115.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$98.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$173.00
D3320	Endodontic therapy, bicuspid tooth.	$204.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$267.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$102.00
D3346	Retreatment of previous root canal therapy - anterior.	$215.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$248.00
D3348	Retreatment of previous root canal therapy - molar.	$308.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$178.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$205.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$222.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$79.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$113.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$57.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$155.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$78.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$284.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$142.00
D4263	Bone replacement graft - first site in quadrant.	$93.00
D4264	Bone replacement graft - each additional site in quadrant.	$70.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$46.00
D4270	Pedicle soft tissue graft procedure.	$209.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$221.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$258.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$124.00
D4275	Soft tissue allograft.	$221.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$258.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 3 PROCEDURES

		Maximum Covered Expense
CROWN LENGTHENING		
D4249	Clinical crown lengthening - hard tissue.	$171.00
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$58.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$29.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$43.00

CHEMOTHERAPEUTIC AGENTS: D4381
- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$308.00
D5120	Complete denture - mandibular.	$299.00
D5130	Immediate denture - maxillary.	$334.00
D5140	Immediate denture - mandibular.	$323.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$222.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$257.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$222.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$257.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$191.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$222.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$257.00
D5810	Interim complete denture (maxillary).	$136.00
D5811	Interim complete denture (mandibular).	$143.00
D5820	Interim partial denture (maxillary).	$120.00
D5821	Interim partial denture (mandibular).	$126.00
D5860	Overdenture - complete, by report.	$308.00
D5861	Overdenture - partial, by report.	$357.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$308.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$357.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$308.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$357.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079
- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$17.00
D5411	Adjust complete denture - mandibular.	$16.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$18.00
D5422	Adjust partial denture - mandibular.	$17.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$40.00
D5660	Add clasp to existing partial denture.	$46.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$112.00
D5711	Rebase complete mandibular denture.	$119.00
D5720	Rebase maxillary partial denture.	$107.00
D5721	Rebase mandibular partial denture.	$113.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$31.00
D5851	Tissue conditioning, mandibular.	$34.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$257.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$280.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$280.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$257.00
D6062	Abutment supported cast metal crown (high noble metal).	$280.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$280.00
D6064	Abutment supported cast metal crown (noble metal).	$304.00
D6065	Implant supported porcelain/ceramic crown.	$257.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$257.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$280.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$280.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$257.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$280.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$280.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$304.00
D6075	Implant supported retainer for ceramic FPD.	$257.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$280.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$280.00
D6094	Abutment supported crown - (titanium).	$280.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$280.00
D6205	Pontic - indirect resin based composite.	$231.00
D6210	Pontic - cast high noble metal.	$280.00
D6211	Pontic - cast predominantly base metal.	$280.00
D6212	Pontic - cast noble metal.	$304.00
D6214	Pontic - titanium.	$280.00
D6240	Pontic - porcelain fused to high noble metal.	$280.00
D6241	Pontic - porcelain fused to predominantly base metal.	$280.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$257.00
D6245	Pontic - porcelain/ceramic.	$257.00
D6250	Pontic - resin with high noble metal.	$280.00
D6251	Pontic - resin with predominantly base metal.	$257.00
D6252	Pontic - resin with noble metal.	$304.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$93.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$93.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$229.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$251.00
D6602	Inlay - cast high noble metal, two surfaces.	$206.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$226.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$178.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$195.00
D6606	Inlay - cast noble metal, two surfaces.	$187.00
D6607	Inlay - cast noble metal, three or more surfaces.	$206.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$247.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$272.00
D6610	Onlay - cast high noble metal, two surfaces.	$226.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$249.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$195.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$215.00
D6614	Onlay - cast noble metal, two surfaces.	$206.00
D6615	Onlay - cast noble metal, three or more surfaces.	$226.00
D6624	Inlay - titanium.	$226.00
D6634	Onlay - titanium.	$249.00
D6710	Crown - indirect resin based composite.	$231.00
D6720	Crown - resin with high noble metal.	$280.00
D6721	Crown - resin with predominantly base metal.	$145.00
D6722	Crown - resin with noble metal.	$234.00
D6740	Crown - porcelain/ceramic.	$257.00
D6750	Crown - porcelain fused to high noble metal.	$304.00
D6751	Crown - porcelain fused to predominantly base metal.	$280.00
D6752	Crown - porcelain fused to noble metal.	$257.00
D6780	Crown - 3/4 cast high noble metal.	$304.00
D6781	Crown - 3/4 cast predominantly base metal.	$280.00
D6782	Crown - 3/4 cast noble metal.	$257.00
D6783	Crown - 3/4 porcelain/ceramic.	$257.00
D6790	Crown - full cast high noble metal.	$280.00
D6791	Crown - full cast predominantly base metal.	$280.00
D6792	Crown - full cast noble metal.	$257.00
D6794	Crown - titanium.	$280.00
D6940	Stress breaker.	$78.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$84.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$84.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$45.00
D9973	External bleaching - per tooth.	$28.00
D9974	Internal bleaching - per tooth.	$34.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

ORTHODONTIC EXPENSE BENEFITS

Class Number 1

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

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TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 2

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

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b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

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3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 3

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

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5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
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10. To replace lost or stolen appliances.

Class Number 5

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

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4. if the Insured's insurance under this section terminates.

5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

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7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

8. because of war or any act of war, declared or not.

9. To replace lost or stolen appliances.

Class Number 6

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

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7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

8. because of war or any act of war, declared or not.

9. To replace lost or stolen appliances.

Class Number 7

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

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COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

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EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

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2. for a Program begun before the Insured became covered under this section.

3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

4. if the Insured's insurance under this section terminates.

5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

8. because of war or any act of war, declared or not.

9. To replace lost or stolen appliances.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the child's dental and/or eye care expenses of the Dependent child, the plan covering the Dependent child shall follow the order of benefit determination as stated in 2.b. above.

    d. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    e. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee,

member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

g. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

If expenses were incurred by a covered person due to the negligence of a third party, we have the right to recover the payments we made for those expenses from any and all damages collected from a third party for those same expenses, whether by action at law, settlement, or compromise. We have the right to recover these payments, to the extent of the payments we made, by the covered person, covered person's parents, if the covered person is a minor, or covered persons' legal representative.

We shall have the right to reimbursement out of all funds the covered person, the covered person's parents, if the covered person is a minor, or the covered person's legal representative, is or was able to obtain for the same expenses we have paid.

You are required to furnish us with any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of nine percent per year on benefits for valid claims not paid within 30 days until the claim is settled. Interest amounting to less than one dollar will not be paid.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	20%
Number of Members-	10

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: NATIONAL ASSOCIATION OF REALTORS

whose main office address is: 430 N MICHIGAN AVE
CHICAGO, IL 60611-4011

for Group Policy No. 10-350635

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

NATIONAL ASSOCIATION OF REALTORS

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

Biography

NATIONAL ASSOCIATION OF REALTORS®
The Voice For Real Estate®

500 New Jersey Avenue, NW
Washington DC 20001

PUBLIC AFFAIRS

For Further Information Contact:
Lucien Salvant, 202/383-1176
lsalvant@realtors.org

VICKI COX GOLDER
NATIONAL ASSOCIATION OF REALTORS®
2010 PRESIDENT

Vicki Cox Golder, a REALTOR® from Tucson, Ariz., is the 2010 president of the NATIONAL ASSOCIATION OF REALTORS®. NAR, The Voice for Real Estate®, is America's largest trade association, representing 1.2 million members involved in all aspects of the residential and commercial real estate industries.

Golder, a REALTOR® for 37 years, is owner of Vicki L. Cox & Associates in Tucson, specializing in commercial, farm and land brokerage, as well as building and development. She holds the professional designations of Certified Real Estate Brokerage Manager (CRB).

At the national level, Golder has served on NAR's Board of Directors since 1993, and previously served as president-elect in 2009 and as first vice president in 2008. She chaired the Issues Mobilization Committee in 2000 and the Political Communications Committee in 1997; she also chaired the Board Leadership Forums in 1995 and Large Board Subforums in 1993. In 2005, she served as NAR's regional vice president for Region XI, which includes Arizona, Colorado, Nevada, New Mexico, Utah and Wyoming. Other committee service includes Political Action, and Land Use and Environment. In 2003, Golder was liaison to the State and Political Issues committees. She has been an RPAC Trustee since 2002.

Golder was president of the Arizona Association of REALTORS® in 1994, where she earlier served as president-elect and vice president. She chaired the association's Government Key Result Area in 1995 and 2003, the Political Affairs Committee in 1991 and 1992, and the Professional Standards Committee in 1989. Other committee service includes Executive, Issues Mobilization, and Strategic Planning; she was a state RLI director in 1986 and 1987.

At the local level, Golder currently serves on the AE Search Committee of the Tucson Association of REALTORS®. She was president of the Tucson Association in 1991 and earlier served as president-elect and vice president. She chaired several committees including Candidate Interview in 2003, Government Affairs in 2002, Bylaws from 1999 to 2001 and 1987 to 1988, Political Affairs in 1992, and Professional Standards in 1985. Golder was co-chair of the Legislative Committee in 2000. She was named "REALTOR® of the Year" by her peers in 1989.

Cox Golder Bio – Add One

Active in her community, Golder currently serves on the Pima County Board of Adjustments. She also has served on the Tucson Metropolitan Chamber of Commerce Executive Committee. She was President of Catalina Community Services in 2002 and 2003, first vice-chairman of Pima County Republican Party from 1999 to 2004 and has been chairman of the Golder Ranch Fire District Board from 1989 to present.

A strong proponent of education, Golder has been on the Arizona Odyssey of the Mind Board since 2001 and has judged at the local, state, and world levels for the organization. She resides in Tucson with her husband, Lloyd.

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Biography

NATIONAL ASSOCIATION OF REALTORS®
The Voice For Real Estate®

500 New Jersey Avenue, NW
Washington DC 20001

PUBLIC AFFAIRS

For Further Information Contact:
Lucien Salvant, 202/383-1176
lsalvant@realtors.org

RONALD PHIPPS
NATIONAL ASSOCIATION OF REALTORS®
2010 PRESIDENT-ELECT

Ronald Phipps, a REALTOR® from Warwick, Rhode Island., is the 2010 president-elect of the NATIONAL ASSOCIATION OF REALTORS®. NAR, The Voice for Real Estate®, is America's largest trade association, representing 1.2 million members involved in all aspects of the residential and commercial real estate industries.

Phipps, a REALTOR® for 31 years, is principal broker of Phipps Realty Inc. in Warwick, R.I., specializing in residential brokerage. He holds the professional designations of Graduate, REALTOR® Institute (GRI) Certified Residential Specialist (CRS), Accredited Buyer Representative (ABR), GREEN and e-PRO certification. He graduated from the College of the Holy Cross, Worcester, Mass., in 1979.

At the national level, Phipps served as first vice president in 2009 and as a national director since 2000. He was a 2006 presidential liaison for Housing and Diversity. In 2004, Ron was the presidential liaison for Information, Education and Conventions. Phipps' accomplishments include Operation Home Delivery, NAR's and Habitat International's joint venture to build 54 homes in the Gulf region for Katrina victims. In 2003, Phipps was a NAR's Region I vice president, which includes Massachusetts, Connecticut, Rhode Island, Vermont, New Hampshire and Maine. He chaired NAR's President's Advisory Group (PAG) for the Virtual Office Websites (VOW) work group and also chaired NAR's PAG on MLS Rules and Regulations and was a member of NAR's PAG on Buyer Brokerage.

At the state level, Phipps was president of the Rhode Island Association of REALTORS® in 2000. He was also president of State-Wide Multi-Listing Service (MLS), Inc. in 1993. Phipps was named the Rhode Island's "REALTOR® of the Year" by his peers in 1995.

Active in his community, he was one of ten finalists in the NAR "Good Neighbor Awards" in 2001 for his volunteer work with the D.A.R.E. Bike Safety Program which, with corporate sponsors, distributed helmets to kids for free. He is an avid traveler, art buff and triathlete. He has completed the 2000 Florida Ironman, the 2000 Boston Marathon and Fourteen Save the Bay Swims.

###

Biography

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500 New Jersey Avenue, NW
Washington DC 20001

PUBLIC AFFAIRS

For Further Information Contact:
Lucien Salvant, 202/383-1176
lsalvant@realtors.org

MOE VEISSI
NATIONAL ASSOCIATION OF REALTORS®
2010 FIRST VICE PRESIDENT

Maurice "Moe" Veissi, a REALTOR® from Miami, Fla., is the 2010 first vice president nominee of the NATIONAL ASSOCIATION OF REALTORS®. NAR, The Voice for Real Estate®, is America's largest trade association, representing 1.2 million members involved in all aspects of the residential and commercial real estate industries.

Veissi, a REALTOR® for 40 years, is broker/owner of Veissi & Associates Inc., in Miami, and specializes in land acquisition.

Veissi served as the 2008 Political Fundraising Chair for the REALTORS® Political Action Committee. He also served on the Strategic Investment Reserve Advisory Board for NAR as well as a regional vice president for Region V in 2005. Veissi has served on NAR's Board of Directors since 1999 as well as on numerous NAR committees.

The Florida Association of REALTORS® (F.A.R) elected Veissi president in 2002. Over the years, he has had the opportunity to chair most of the association's committees. F.A.R. named Veissi "REALTOR® of the Year" in 2003.

On the local level, Veissi served as president of the REALTOR® Association of Greater Miami and The Beaches in 1981.

Active in his community, Veissi founded the Silent Angels Charitable Foundation. He has coached several youth sports teams as well as volunteered with Habitat for Humanity, Camillus House for the Homeless, and the Athletic Committee of Columbus High School. The City of Coral Gables twice appointed him as Economic Development Chairman.

Veissi and his wife, Matey, have two sons.

# # #

Biography

NATIONAL ASSOCIATION OF REALTORS®
The Voice For Real Estate®

500 New Jersey Avenue, NW
Washington DC 20001

PUBLIC AFFAIRS

For Further Information Contact:
Lucien Salvant, 202/383-1176
lsalvant@realtors.org

VINCE MALTA
NATIONAL ASSOCIATION OF REALTORS®
2010 VICE PRESIDENT AND LIAISON TO GOVERNMENT AFFAIRS

Vince Malta, a REALTOR® in San Francisco, Calif., is the 2010 Vice President and Liaison to Government Affairs for the NATIONAL ASSOCIATION OF REALTORS®. NAR, The Voice for Real Estate®, is America's largest trade association, representing 1.2 million REALTORS® involved in all aspects of the residential and commercial real estate industries.

Malta is a third-generation REALTOR® and the CEO and founder of Malta & Co., Inc. He is a graduate of the University of San Francisco and the University of San Francisco School of Law. Malta has been in the real estate business for over 25 years and has served the industry in countless roles.

On the national level, Malta has testified before Congress multiple times on behalf of NAR on issues like the impact of increasing conforming loan limits and reforming GSE regulations. He served on the NAR Board of Directors from 2002 - 2006 as well as from 1995 - 1996.

Malta has experience serving on numerous NAR committees, like Business Issues, Mold Advisory, Property Management, and Commercial Finance.

Since 1993, Malta has been deeply involved with the California Association of REALTORS® (C.A.R.). In 2006, C.A.R. elected him president. He has served as a C.A.R. director since 1998 and is also an Honorary State Director for Life. More recently, he chaired the Association Presidents Leadership Forum in 2003 and the C.A.R. Leadership Development Forum in 2002.

Malta sat on the Board of Directors of the San Francisco Association of REALTORS® from 1987-1994. The board voted him REALTOR® of the Year in 1996.

Malta lives with his wife, Julie, and their three sons in San Francisco. He plays the clarinet and the saxophone. On the side, he has a business authenticating professional baseball bats. He also participates in sport class auto racing in his spare time.

Biography

NATIONAL ASSOCIATION OF REALTORS®
The Voice For Real Estate®

500 New Jersey Avenue, NW
Washington DC 20001

PUBLIC AFFAIRS

For Further Information Contact:
Lucien Salvant, 202/383-1176
lsalvant@realtors.org

BROOKE HUNT
NATIONAL ASSOCIATION OF REALTORS®
2010 VICE PRESIDENT AND LIAISON TO COMMITTEES

Brooke Hunt, a REALTOR® from Flower Mound, Texas, is the 2010 Vice President and Liaison to Committees for the NATIONAL ASSOCIATION OF REALTORS®. NAR, "The Voice for Real Estate®," is America's largest trade association, representing 1.2 million REALTORS® involved in all aspects of the residential and commercial real estate industries.

A REALTOR® for more than 23 years, Hunt works with Keller Williams Realty, a full-service real estate firm.

Active in the national association, she has been a NAR Board of Directors member since 2001. She has served on various committees, including Professional Standards, Public Policy Coordinating, and the Political Advocacy Advisory Group. In 2006, Hunt chaired the REALTOR® Political Involvement Committee. Most recently, she served on the Executive Committee in 2008.

The Texas Association of REALTORS® (TAR) elected Hunt as Chairman in 2009. She served as a delegate at several state political conventions and as a team leader for a Texas Senator. She has also been a Texas Real Estate Political Action Committee (TREPAC) trustee, chairman of the Political Affairs Committee, and a member of the legislative committee.

TAR named Hunt the 1998 Future Leader of the Year and the 1999 Senatorial Contact Person of the Year.

Hunt has held every key leadership role at the MetroTex Association of REALTORS®, including serving as Director from 1995 - 2002 and President of the board in 1999. The Northeast Tarrant County Board of REALTORS® named her REALTOR® of the Year in 1998.

In Flower Mound, Hunt lives with her husband, Michael, who is a partner in their real estate business. Their daughter Emily is a sophomore at Texas Tech University.

Biography

NATIONAL ASSOCIATION OF REALTORS®
The Voice For Real Estate®

500 New Jersey Avenue, NW
Washington DC 20001

PUBLIC AFFAIRS

For Further Information Contact:
Lucien Salvant, 202/383-1176
lsalvant@realtors.org

VINCE MALTA
NATIONAL ASSOCIATION OF REALTORS®
2010 VICE PRESIDENT AND LIAISON TO GOVERNMENT AFFAIRS

Vince Malta, a REALTOR® in San Francisco, Calif., is the 2010 Vice President and Liaison to Government Affairs for the NATIONAL ASSOCIATION OF REALTORS®. NAR, The Voice for Real Estate®, is America's largest trade association, representing 1.2 million REALTORS® involved in all aspects of the residential and commercial real estate industries.

Malta is a third-generation REALTOR® and the CEO and founder of Malta & Co., Inc. He is a graduate of the University of San Francisco and the University of San Francisco School of Law. Malta has been in the real estate business for over 25 years and has served the industry in countless roles.

On the national level, Malta has testified before Congress multiple times on behalf of NAR on issues like the impact of increasing conforming loan limits and reforming GSE regulations. He served on the NAR Board of Directors from 2002 - 2006 as well as from 1995 - 1996.

Malta has experience serving on numerous NAR committees, like Business Issues, Mold Advisory, Property Management, and Commercial Finance.

Since 1993, Malta has been deeply involved with the California Association of REALTORS® (C.A.R.). In 2006, C.A.R. elected him president. He has served as a C.A.R. director since 1998 and is also an Honorary State Director for Life. More recently, he chaired the Association Presidents Leadership Forum in 2003 and the C.A.R. Leadership Development Forum in 2002.

Malta sat on the Board of Directors of the San Francisco Association of REALTORS® from 1987-1994. The board voted him REALTOR® of the Year in 1996.

Malta lives with his wife, Julie, and their three sons in San Francisco. He plays the clarinet and the saxophone. On the side, he has a business authenticating professional baseball bats. He also participates in sport class auto racing in his spare time.

Biography

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PUBLIC AFFAIRS

For Further Information Contact:
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lsalvant@realtors.org

JAMES HELSEL
NATIONAL ASSCIATION OF REALTORS®
2010 TREASURER

James L. Helsel, Jr., a REALTOR® from Lemoyne, Pa., is 2010 Treasurer of the NATIONAL ASSOCIATION OF REALTORS®. NAR, the Voice for Real Estate®, is America's largest trade association, representing more than 1.2 million members involved in all aspects of the residential and commercial real estate industries.

Helsel, a REALTOR® for 35 years, is a Principal with RSR Realtors, a full-service real estate company in Harrisburg, Pa. He holds the professional designations of Certified Property Manager® (CPM), Graduate, REALTOR® Institute (GRI), and Certified Commercial Investment Member (CCIM). He is also a member of the Council of Real Estate Brokerage Managers (CRB), Counselors of Real Estate (CRE), and Society of Industrial and Office REALTORS® (SIOR).

On the national level, Helsel was treasurer in 2008 and 2009 and a member of the NAR Board of Directors from 1989 until 1999 and joined again in 2001. He was a member of NAR's Finance Committee in 2002 and 2003, and again from 2005 to 2007. He served as NAR's 2001 regional vice president for Region II, which includes Pennsylvania, New Jersey and New York. He chaired the Real Property Operations Committee in 2002 and 2003, which was responsible for building NAR's award-winning Washington, D.C. headquarters. He has served on NAR's Executive Committee and Strategic Planning Committee as well as numerous Presidential Advisory Groups (PAGs). He is a four time "Golden R" Member of RPAC and a member of the NAR RPAC Hall of Fame.

In 1994, he was president of the Pennsylvania Association of REALTORS®. In 2001, he was selected "REALTOR® of the Year" by his state peers.

At the local level, Helsel served as president of the Greater Harrisburg Association of REALTORS® in 1983. He was named "REALTOR® of the Year" by his local peers in 1985. The IREM Delaware Valley Chapter selected him as CPM of the Year in 1987.

Active in his community, Helsel was Chairman of the Board of Trustees of the Cornwall Manor Home, a 550 bed continuing care facility for the elderly, from 1997 to 2000 and has continually served on the Capital Region United Way Allocations and Venture Grant Committees. He also serves on the Governmental Affairs Committee of the Regional Chamber and chairs the Chamber's PAC.

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The National Association of REALTORS®

All Together

100 Years of Teamwork

2008 ANNUAL REPORT

The Voice for Real Estate®

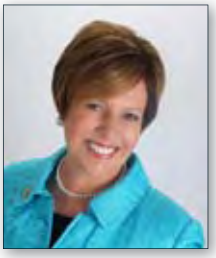
2008 NAR Leadership Team

Richard F. "Dick" Gaylord
CIPS, CRB, CRS, GRI
President

Charles McMillan
GRI, CIPS
President-Elect

Vicki Cox Golder
CRB
First Vice President

James L. Helsel, Jr.
CPM, GRI, CCIM, CRB, CRE, SIOR
Treasurer



Pat V. Combs
ABR, CRS, GRI, PMN
Immediate Past President

Robert Kulick
CCIM, GRI
Vice President & Liaison to Government Affairs

Mark Foreman
Vice President & Liaison to Committees

Dale Stinton
CAE, CPA, CMA, RCE
Chief Executive Officer

Regional Vice Presidents

Judy Moore, CRS, GRI, PMN, SRES, Region 1 *(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont)*

Mary Davis, ABR, GRI, Region 2 *(New Jersey, New York and Pennsylvania)*

Elizabeth Blakeslee, e-PRO, GRI, Region 3 *(Delaware, District of Columbia, Maryland, Virginia and West Virginia)*

Donna Smith, CRB, CRS, GRI, Region 4 *(Kentucky, North Carolina, South Carolina and Tennessee)*

Randy McKinney, Region 5 *(Alabama, Florida, Georgia, Mississippi, Puerto Rico and the Virgin Islands)*

Barbara Lach, ABR, CRB, CRS, GRI, PMN, Region 6 *(Michigan and Ohio)*

John Veneris, CRB, CRS, Region 7 *(Illinois, Indiana and Wisconsin)*

Dan Berry, ABR, GRI, SRES, Region 8 *(Iowa, Minnesota, Nebraska, North Dakota and South Dakota)*

Sam Rader, CRB, GRI, Region 9 *(Arkansas, Kansas, Missouri and Oklahoma)*

Virginia Cook, CRB, Region 10 *(Louisiana and Texas)*

Bob Snowden, GRI, Region 11 *(Arizona, Colorado, Nevada, New Mexico, Utah and Wyoming)*

Michael J. Flynn, ABR, CRS, GRI, SRES, Region 12 *(Alaska, Idaho, Montana, Oregon and Washington)*

Robert Bailey, CRB, Region 13 *(California, Guam and Hawaii)*

NAR Senior Staff

Dale Stinton
CAE, CPA, CMA, RCE
Chief Executive Officer

Janet Branton
CAE, CIPS
Senior Vice President, AE/Leadership, International & Specialities

Jerry Giovaniello
Senior Vice President, Government Affairs & Chief Lobbyist

Bob Goldberg
Senior Vice President, Marketing, Business Development & Commercial Services Group

Doug Hinderer
Senior Vice President, Human Resources & Office Services

Laurie Janik
Senior Vice President, General Counsel, Law & Policy

Mark Lesswing
Senior Vice President, Chief Technology Officer

Frank Sibley
Senior Vice President, Communications & Convention

Walt Witek
Senior Vice President, Community & Political Affairs

Lawrence Yun
Senior Vice President, Research & Chief Economist

Message from 2008 NAR President Dick Gaylord

"All Together." Those two simple words speak volumes about how 1.2 million REALTORS® turned a year of uncertainty and unexpected challenges into a new century of potential opportunities.

Throughout 2008, I had the opportunity to travel across the country and around the world, representing the National Association of REALTORS®. I was astounded by how willing REALTORS® are to contribute to something bigger than themselves. We worked as a team like never before to address challenges in the economy, the real estate market and our businesses. More importantly, we helped support each other.

The 2008 Annual Report provides a record of a landmark year in NAR's history of service to real estate professionals and our nation. When you consider all that we accomplished last year, three words come to mind: Innovate, Advocate and Celebrate.

Innovate

In 2008, NAR proved that the spirit of innovation that led to our creation in 1908 is alive and well today. We explored new methods of communication, educational opportunities and technology to help our members do business in a tough environment. At the same time, we launched the first in our series of Second Century Initiatives that will give REALTORS® a significant advantage in the real estate business in the decades ahead.

Advocate

On the public policy front, NAR again showed that we continue to be the voice for our industry and consumers on laws and policies that impact real estate and the nation. We pushed for legislation to stimulate housing investment, stem foreclosures, and limit the decline in real estate and the national economy. At the same time, we supported a myriad of successful candidates in a watershed election, securing our influence with a new Congress and a new Administration.

Celebrate

NAR's work in 2008 is a tribute to what has made this association an American institution for 100 years. It's appropriate that we took time throughout the year to celebrate our history and accomplishments. I, for one, will never forget the once-in-a-lifetime celebration at the Midyear Legislative Meetings and the incredible REALTORS® Conference & Expo in Orlando.

In each and every way, NAR made 2008 a brilliant end to our first 100 years and created a beacon for all those who follow in our footsteps. I have never been more proud to serve this association.

On behalf of the entire 2008 Leadership Team and the NAR staff, I thank you for your hard work last year. May this report serve as a proud record of what we accomplished "All Together" and inspire all REALTORS® to serve in the years ahead.

Innovate

\in-uh-veyt\ (verb)

1. To introduce something new as if for the first time.
2. To make changes in anything established.

The National Association of REALTORS® helps its members reach new levels of success through its commitment to innovation. NAR created new tools and resources in 2008 to make communication more effective, unlock more business opportunities, increase commercial real estate prospects, pave new roads for housing opportunity, and help REALTORS® take advantage of technology.

Communicating in New and Compelling Ways

Through national advertising campaigns, the Internet, social media, and a host of other channels, NAR placed a high priority on communication to swiftly and creatively deliver important information to REALTORS® and consumers.

NAR's Public Awareness Campaign delivered powerful messages to national audiences through a comprehensive media buy – messages that not only endorsed the benefits of using a REALTOR® but also countered negative housing market messages. The campaign featured two informative ads aimed directly at first-time home buyers. One emphasized the importance of homeownership in creating long-term wealth, while the other demonstrated the enduring value of homeownership, despite temporary market declines.

Public Awareness Campaign

As part of the campaign, NAR also launched HousingMarketFacts.com, a companion Web site for consumers. The site features detailed information about the value of homeownership, allows consumers to do their own research on current housing market trends, and helps buyers and sellers find a REALTOR®.

Long-term tracking research shows that the Public Awareness Campaign positively influenced consumers' attitudes toward REALTORS® and the value of homeownership.

To generate positive buzz about REALTORS® and homeownership opportunities in local markets, NAR created the Surround Sound Campaign. This program teaches REALTORS® how to pitch positive news stories to local news outlets and to organize and implement grassroots outreach that delivers positive real estate messages straight to consumers.

NATIONAL ASSOCIATION OF REALTORS®
Surround Sound Campaign

Surround Sound Campaign logo

More than 30 state and local associations launched campaigns to promote Surround Sound messages, and NAR distributed more than 600 toolkits to members.

NAR's Research Department developed innovative communication tools, as well. Chief Economist Lawrence Yun and his staff delivered daily economic commentaries on REALTOR.org, explaining the latest trends affecting the housing market. They also created an economic concepts glossary to help REALTORS® understand puzzling market news. To further explain research data, NAR designed an interactive map to accompany regional home sales statistics on REALTOR.org. More than half a million people visited the Research Web pages.

When Congress included the $7,500 first-time home buyer tax credit in the Housing and Economic Recovery Act of 2008, the Research Department quickly produced the "Save Now with Homebuyer Tax Credit" brochure so REALTORS® could explain the advantage to clients and use it to improve sales.

At the same time, NAR helped the Leadership Team communicate in new ways.

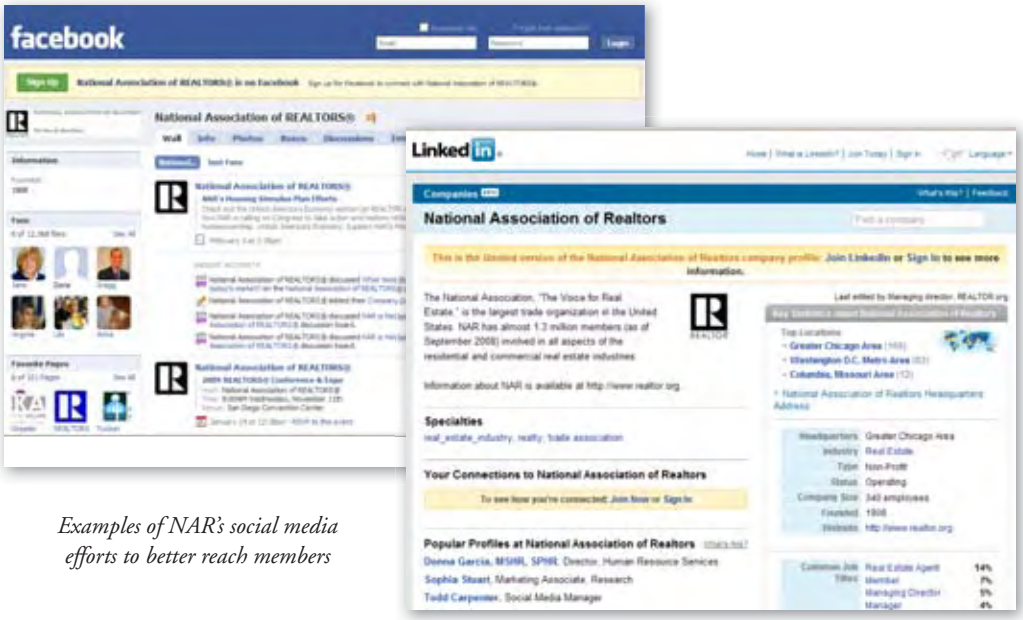
NAR continued to explore other forms of social media, creating pages on Facebook and LinkedIn®.

These Web pages provide networking opportunities for NAR and enabled REALTORS® to expand their client base. NAR used Twitter to keep members informed during the Midyear Legislative Meetings & Trade Expo and the REALTORS® Conference & Expo. We even helped members experience the REALTORS® Conference & Expo from their home or office, via a live Web page that staff consistently updated with videos, photos, polls, and RSS feeds.

In the fall, NAR launched REALTOR®TV, an online library of all videos and podcasts, including videos with business tips and our existing-home sales press conferences. Members could even upload their own videos to the library, offering advice and guidance to colleagues on a wide range of topics like "going green" at home or the luxury home market.

NAR also improved our REALTOR® Virtual Library, providing audio books that members can download on iPods and giving members the option to write their own book reviews for titles.

We formed a presence on the Web site Second Life. Second Life is an online, virtual world where participants invent an alternate identity and travel, run businesses, and even buy real estate. NAR hosted real-time meetings on Second Life for the Association Executive Work Group on social media and a Member Information Services Forum at both the Midyear Legislative Meetings & Trade Expo and the REALTORS® Conference & Expo. Members can use the site to practice real estate transaction skills.



Examples of NAR's social media efforts to better reach members

Video Podcast

We expanded the popular President's Podcast series, to include 12 video editions along with the established audio versions, which are posted on REALTOR.org and on iTunes. The video podcasts were played more than 86,000 times last year.

"I wanted to personally let fellow REALTORS® know what was happening at NAR, and how we were working to help them in a difficult market."

Dick Gaylord, 2008 NAR President

Creating New Business Opportunities

NAR developed new resources and training tools to help REALTORS® facilitate more business transactions and increase their client base and profitability.

Short sales increased during the year, becoming a larger portion of the home sales market. NAR worked with Freddie Mac to help develop the Freddie Mac Short Sales Webinar. The course was made available online, and free to members. Information Central staff also collated research materials, articles, and eBooks pertaining to short sales and catalogued all information online for member use.

While the Federal Housing Administration had been a popular resource for first-time home buyers in the past, the subprime lending market overtook FHA during the real estate boom. Now that demand is rising for FHA-insured mortgages, NAR developed the FHA Toolkit to help REALTORS® guide their buyers through the process.

FHA Toolkit

> "Being able to offer FHA programs to potential buyers can really make a difference in the current market."
>
> ***Lois Killebrew, 2008 Chair, Federal Housing Policy Committee***

NAR helped members understand the new Real Estate Settlement Procedures Act guidelines by hosting a Web conference with noted RESPA attorney Phil Schulman. The conference explained the main provisions and allowed time for members to get answers to their individual questions.

To meet the demand for green home features and educate members on real estate environmental protections, NAR created the Green Designation. By earning this designation, REALTORS® are prepared to counsel clients, manage green properties, and spread the green philosophy in the community. NAR also created a comprehensive curriculum to educate members on EPA's new lead-based paint renovation, repair, and painting rules.

NAR's new green designation logo

To enhance communication between members and consumers, NAR partnered with the REALTOR® Association of Greater Miami and the Beaches and the Virginia Association of REALTORS® to develop home buyer financial assistance Web sites. These sites help consumers obtain financial guidance through local resources.

REALTOR.com added more upgrades and savings for members, including a photo carousel that now features property listings on the homepage. Members can post four extra photos for free with their membership. The site also features school and neighborhood information and attaches an interactive map to every listing. Members with enhanced privileges gained even more benefits with the Find Home Values function, which reports on the productivity of buying and selling agents on recently sold listings.

To help members take full advantage of the new upgrades, NAR developed TourTheNewREALTOR.com, a virtual open house that provides an online tutorial.

REALTOR.com remained the most visited real estate Web site, with the most listings, the most traffic, and the largest audience in comparison to the next three leading real estate Web sites.

Creating Opportunities for Commercial Practitioners

"NAR understands how important the commercial sector is to our entire economy. This is a great example of our association's efforts."

Jim Helsel, 2008 NAR Treasurer

NAR also continued its work to strengthen the commercial real estate market.

NAR launched CommercialSource.com to deliver a one stop-shop for commercial real estate practitioners to find property listings, participate in the Online Convention and Tradeshow, access educational resources, and read industry news.

NAR launched CommercialSource.com to deliver a one-stop-shop for commercial real estate practitioners

The REALTORS® Commercial Alliance introduced the Commercial Services Accreditation Program to give national recognition to associations setting commercial service standards. More than 55 associations earned accreditation by the end of 2008. The accreditation helps associations offer more resources to current members and attract new members, as well.

Through the Signature Series Grant Program professional development opportunities were expanded to include topics such as strategic planning, commercial fundamentals and technology at the state and local levels, too. The program funds top-notch training seminars, connects associations with nationally recognized speakers, and provides commercial members with important professional development.

The Commercial Division also hosted more than 25 live Webinars for members on commercial real estate. Many of the Webinars sold out.

In December, commercial real estate leaders and industry representatives convened in Washington, D.C., to develop a stimulus plan to bolster the commercial market. The Commercial Real Estate Economic Stimulus Proposal included provisions to stabilize and provide liquidity to the commercial credit market, maintain and enhance federal tax policies that strengthen the market, and stimulate the commercial market through investment.

Promoting Housing Opportunity

> "While progress has been made in meeting the goals of the Fair Housing Act, more work needs to be done to increase awareness of fair housing laws, improve access to affordable housing and promote inclusion and diversity in our communities."
>
> ***Pat V. Combs, 2008 NAR Immediate Past President***

The 2008 Housing Opportunity Pulse Survey found that most Americans believe owning a home is a good financial investment. To make that dream a reality for more people, NAR worked to increase housing opportunities across the country.

NAR renewed its partnership with the U.S. Conference of Mayors and named six more cities as Ambassador Cities, highlighting them for their work promoting affordable housing.

Asheville, N.C. earns Ambassador City designation

NAR partnered with the Congressional Black Caucus Foundation, the Congressional Hispanic Caucus Institute, and the Asian-Pacific American Institute for Congressional Studies to create the Real Estate Policy Fellowships. In this graduate-level fellowship program, students spend a year in Washington, D.C., completing a research project related to real estate policy. The program helps train future leaders from diverse communities and educates them on real estate issues.

Approximately 200 REALTORS®, local government officials, employers, and housing advocates attended the first Employer-Assisted Housing Conference sponsored by NAR.

In November, the Board of Directors approved the largest housing opportunity grant program in the association's history. The Ira Gribin Workforce Grants honored the late 1989 NAR president and tireless housing opportunity advocate. The grants will give as much as $5.23 million dollars through 2010 to state and territorial associations or their housing foundations to support workforce housing initiatives. These grants will help teachers, firefighters, public works employees, and retail personnel live in the communities in which they work.

NAR also supported the National Commission on Fair Housing and Equal Opportunity. Topics included the extent of illegal housing discrimination, government policy, and the effect of foreclosures and segregation on communities. Immediate Past President Pat V. Combs participated as a commissioner.

In early December, the commission released its final report concluding that a new independent agency should be created to enforce fair housing laws. It also recommended improved enforcement of fair housing laws, a stronger fair housing focus for government programs, and improved collaboration across the housing community.

Advancing Technology

The *2008 REALTOR® Technology Report* revealed that 65 percent of agents and associate brokers spent up to $2,000 on job-related technology, and NAR continued to help members build their businesses through technology.

The Center for REALTOR® Technology consistently evaluated new technology trends to determine which tools would be most beneficial for REALTORS®. CRT created a new program for the Real Estate Transaction Standard (RETS) that acquired data faster and quicker from multiple listing services. CRT devised another program as well to verify that MLSs are running RETS-compliant servers.

NAR also launched the Leadership Academy Technology Workshops. The workshops encouraged volunteer state leaders to integrate technology into the real estate sales process and explore ways technology could increase sales.

Advocate

\ad-vƏ-,kāt\ (verb)

1. To speak or write in favor of.
2. To support or urge by argument or recommend publicly.

Throughout 2008, the National Association of REALTORS® sought to unlock credit markets, stimulate housing demand and strengthen our communities.

Unlocking Credit Markets

As we welcomed 2008, challenges were already apparent. Frozen credit markets were hurting members' ability to close deals and slowed the national economy. NAR used our influence in Washington, D.C., to help unlock credit markets and restore liquidity to the financial system.

> "In every way, REALTORS® earned the rare distinction to proudly call ourselves the leading advocate for preserving the American Dream of Homeownership." ***Charles McMillan, 2008 NAR President-Elect***

We started by working closely with the U.S. Department of Housing and Urban Development to reinstate the FHA Secure program, a refinancing program within the Federal Housing Administration. The program helped homeowners with high mortgage interest rates refinance into an FHA-insured mortgage. Next, NAR supported the HOPE for Homeowners program sponsored by FHA to help troubled homeowners refinance out of problematic, subprime loans.

NAR helped reinstate FHASecure

Later in the year, NAR urged the overhaul of the regulatory structure of Fannie Mae and Freddie Mac to ensure their financial stability. In September, the federal government assumed control of the government-sponsored enterprises.

NAR also continued to fight to protect consumers in the real estate transaction. We worked directly with Fannie Mae and Freddie Mac to reverse their declining markets policy that unintentionally limited housing opportunities in residential communities where home prices had declined. NAR also urged the Federal Housing Finance Agency to rescind its adverse market fees. At the same time, we also worked to loosen overly strict underwriting standards.

NAR took further action and urged Congress to pass the Emergency Economic Stabilization Act of 2008 to purchase up to $700 billion in troubled assets from institutions to alleviate pressure on the credit markets.


AMERICANS ON EDGE AS CRISIS SHIFTS FROM WALL STREET TO MAIN STREET

"House Rejects Financial Rescue, Sending Stocks Plummeting"
-The Washington Post, September 30, 2008

"Loan Costs Soar As Access Tightens"
-USA Today, September 30, 2008

"The Financial Crisis: Failed Vote Deals Economy Another Blow"
-The Wall Street Journal, September 30, 2008

"Big And Small, Companies Cling To A Thread"
-The Boston Globe, October 1, 2008

Congress cannot stand by as many Americans are finding it more difficult to get home mortgages, secure car loans and borrow money to send their children to college. The financial collapse is threatening ordinary Americans' retirement savings and small businesses across the nation. We must restore confidence in our economy and ensure that America's capital needs are met now and in the future. Congress must pass a recovery plan now.

Contact Congress Today
Tell Them To Pass A Recovery Plan Now
Visit www.MainStreetNeedsYou.org
Call (202) 224-3121

NAR urged Congress to pass a recovery plan to restore confidence in the economy

> "We understand the concerns about the bill, and, frankly, many of us feel the same about some of the provisions. However, as REALTORS®, we also understand better than anyone else how important housing is to our nation's families and to our economy." ***Dick Gaylord, 2008 NAR President***

Throughout the year, NAR pushed for federal legislation and regulations to prevent predatory lending while keeping fair and affordable mortgage lending available.

Stimulating Housing Demand

> "NAR pulled out all the stops when it came to fighting for homeowners and buyers, as well as protecting consumers."
> ***Vicki Cox Golder, 2008 NAR First Vice President***

NAR advocated for provisions to stimulate housing demand. We strove to unlock credit markets to revitalize the housing market. We advocated for policies that provided incentives for home buyers, made housing more affordable and reformed the tax code to benefit consumers.

To stimulate demand for housing, NAR worked to make housing more affordable. We successfully urged Congress to raise loan limits for FHA, Fannie Mae and Freddie Mac from 95 percent of the local area median home price to 115 percent. This move increased affordability, especially in high-cost areas. Low-cost areas experienced a boost, too, as loan limits increased to $271,050 and the high-cost limit increased temporarily to 729,750. Our nation's veterans also benefited when loan limits for them increased to 175 percent of the Freddie Mac/Fannie Mae conforming loan limit through 2011 under the Veterans Administration Home Loan Guaranty Program.

As the year progressed, more action was necessary to stimulate demand for housing. NAR successfully urged Congress to include several of NAR's housing priorities in legislation, including a $7,500 temporary tax credit for first-time home buyers. NAR's Research Department estimated that the tax credit contributed an additional 264,000 home sales in 2008.

NAR also achieved a long-sought goal of modernizing the FHA program. Thanks to NAR's efforts, it is now easier to purchase condominiums with FHA-insured mortgages and FHA is now using automated underwriting to evaluate borrowers with nontraditional credit histories.

NAR's coordinated advertising campaign urged Congress to raise loan limits and pass FHA reform

To increase the supply of affordable and entry-level housing, NAR successfully urged Congress to establish the National Affordable Housing Trust Fund and updated the manufactured housing program.

We also helped consumers through important tax code reforms. NAR urged Congress to extend the mortgage cancellation tax relief to 2012, helping homeowners who had a portion of their mortgage forgiven in either a short sale or foreclosure avoid paying tax on the forgiven amount.

NAR also advocated for an additional standard property tax deduction of $1,000 on a joint return and $500 on a single return for those who do not itemize their deductions.

REALTORS® successfully urged that veterans' service be honored by eliminating the equity requirement and raising the refinancing loan limits to equal the purchase loan limits through the enhanced Veterans Home Loan Guaranty Program. NAR also sought to make housing more affordable for our veterans by advocating that the Veterans Administration be allowed to extend its ability to provide adjustable-rate mortgages through 2012.

NAR helped protect sellers' identities by preventing them from having to disclose their Social Security number at settlement on residential property with an amendment to the Foreign Investment in Real Property Tax Act.

Successful reform of the Real Estate Settlement Procedures Act capped a very active year. Working with the administration, REALTORS® achieved significant reforms in disclosures that will benefit consumers while eliminating provisions that would harm competition and lead to an unlevel playing field for settlement service providers.

The REALTOR® Action Center was responsible for one million letters sent to members of Congress

None of these accomplishments would have been possible without the dedicated efforts of NAR's 1.2 million members. Through the REALTOR® Action Center more than one million letters were sent to members of Congress, and member participation in grassroots advocacy increased by 77 percent. The new Broker Involvement Program, which signed up 433 broker owners representing over 144,000 agents, helped generate NAR's grassroots messages.

NAR also took out full-page advertisements on behalf of our members in major publications such as *USA Today, The Wall Street Journal* and *The Washington Post*, and placed online banner ads on top Internet Web sites. REALTORS® Political Action Committee played an important role in our success spending $14.3 million supporting REALTOR-friendly candidates and party committees. In 2008, RPAC-supported candidates won 94 percent of their races.

NAR's advocacy ads communicated the importance of housing to elected officials

Strengthening Our Communities

"NAR works to enhance every aspect of our communities from the environment, to the protection of property, and most importantly, to the lives of its citizens."
Mark Foreman, 2008 Vice President and Liaison to Committees

While NAR advocated for federal policies to strengthen the housing market and our nation, members worked hard to implement them in their communities.

NAR promoted strong environmental policies to help our members serve more environmentally conscious clients. We urged Congress to extend vital tax credits that provide incentives for energy efficient housing and commercial buildings, which helped make green principles more available and affordable. We also ensured that the deduction for brownfields cleanup expenditures was renewed and extended.

Furthermore, NAR supported legislation making federal assistance available to communities with economies linked to timber harvesting in the national forests.

At the same time, NAR helped our members serve clients in disaster-prone areas. Thanks to our efforts, Congress extended the National Flood Insurance Program which provided coverage for millions of homes and businesses susceptible to floods.

On the commercial side, NAR also helped renew and extend the 15-year life for leasehold improvements through 2009, which encourages commercial property owners to renovate properties.

Throughout the year, NAR continued to address other issues that impacted our members and their businesses. In fact, NAR won a significant victory for REALTORS® helping to pass legislation that prevents them from having to obtain additional licensing for being a tangential participant in the mortgage origination process.

Healthcare

2008 NAR President-Elect Charles McMillan and Senators Dick Durbin (D-Ill.) and Olympia Snow (R-Maine) at the introduction of the SHOP Act to help small businesses obtain quality affordable health coverage

Health insurance for REALTORS® continues to be a major priority. NAR spearheaded legislation in 2008 that laid the groundwork for major health care reform in 2009 through the Small Business Health Options Program, or SHOP, which will help provide quality health insurance that is affordable and available.

Congressman Ron Kind and 2008 NAR Treasurer Jim Helsel at the introduction of the SHOP Act in the U.S. House of Representatives

Celebrate

\ˈse-lə-ˌbrāt\ (verb)

1. To honor, especially by solemn ceremonies or by refraining from ordinary business.
2. To mark by festivities or other deviation from routine.

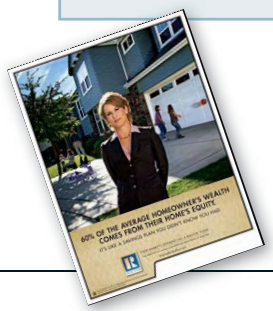
The year 2008 proved to be a pivotal time for REALTORS®. It shined as a year of innovation, communication, creativity and tremendous challenges and opportunities. Yet, despite the many changes we faced in our markets, in our industry, and across the nation, REALTORS® continued to stand undaunted and relentless in their desire to serve their clients and communities. REALTORS® in cities and towns across America rose above their everyday work and maintained a positive outlook and an upbeat attitude. This REALTOR® pride and spirit made our centennial year truly incredible and showed just what has made the National Association of REALTORS® successful for 100 years. Looking back, we have much to celebrate.

2008: A Year to Celebrate

JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE

JANUARY

Public Awareness Campaign ads Launched
January 14



FEBRUARY

Economic Commentaries Began

Economic Stimulus Act of 2008 Becomes Law
February 13

First Video Podcast Created
February 19

FHASecure Reinstated
February 28

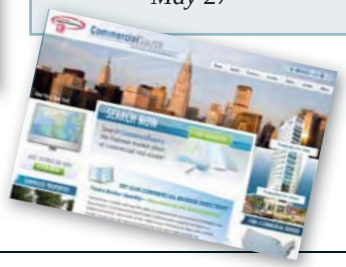
MARCH

Surround Sound Kicked Off
March 1

MAY

CommercialSource.com Launched
May 10

DOJ Case Settled
May 27



"No matter where I traveled, but especially in areas where market conditions were most difficult, I found myself inspired and humbled by the sheer positivity of all REALTORS®. They inspired me to do more for my own clients and for our association. Our success is a credit to them."

Dick Gaylord, 2008 NAR President

JULY AUGUST SEPTEMBER OCTOBER NOVEMBER DECEMBER

TourtheNewREALTOR.com Debuted

The Housing and Economic Recovery Act of 2008 Becomes Law *July 30*

Federal Government Assumes Control of Fannie Mae and Freddie Mac *September 7*

FHA Toolkit Created *September 26*

Emergency Economic Stabilization Act of 2008 Becomes Law *October 3*

REALTOR® TV Launched *November 1*

REALTORS® Conference & Expo begins *November 7*

Commercial Real Estate Economic Stimulus Plan Created *December 16*

Commemorating the Centennial

On May 12, NAR celebrated a once-in-a-lifetime event - its 100th anniversary.

Industry legend Ebby Halliday shared her wisdom and insights with REALTORS® during a special 59 and ½ Minutes: A Member & Director Forum at the Midyear Legislative Meetings & Trade Expo. Ebby also graciously chaired NAR's all-star Centennial Gala, featuring historian Jim Rasenberger, author of the book *America 1908*, and the entire 2008 Leadership Team.

To ensure that our great history lives on for generations, NAR published a special Centennial book, *100 Years in Celebration of the American Dream*, and companion video for REALTORS® and the public. The materials chronicle the history of America's largest professional trade association, from its founding in a Chicago YMCA in 1908 to its current position as the "Voice for Real Estate."

"Playwright George Bernard Shaw once said, "Life is no brief candle to me. It is a splendid torch which I hold for the moment. I want to make it burn as brightly as possible before handing it on to future generations.' For 100 years, NAR has carried a splendid torch that has burned brightly from one generation to the next." ***Charles McMillan, 2008 NAR President-Elect***

The celebration didn't end there. NAR also helped REALTORS® commemorate the centennial throughout the year with numerous other events.

Thousands of members all across the country submitted photos for a unique mosaic ad. We also created a special timeline of notable events in our history so that members and the public could appreciate and understand how our incredible organization has grown and shaped our industry and our nation.

On January 1, 2009, NAR capped a yearlong celebration in grand style with its first-ever float in the Tournament of Roses Parade. The float's theme, "Celebrating the Dream of Homeownership for 100 Years," showcased the work REALTORS® do every day to make homeownership possible and underscored that home is wherever the heart is. More than 30 million Americans and people around the world watched NAR's entry win the coveted the Isabella Coleman Trophy for "Best Presentation of Color and Color Harmony through Floral Use."

100 Years of Teamwork

1908 The National Association of Real Estate Exchanges is founded

1911 First permanent headquarters in Minneapolis

1913 National Association adopted its Code of Ethics

1916 Association name is changed to National Association of Real Estate Boards, and REALTOR® name is adopted

1920 Headquarters moved from Minneapolis to Chicago

1923 National Association of Real Estate Boards emblem is adopted

1938 Women's Council of REALTORS® is founded

1942 Association leaders establish the REALTOR® Washington Committee

Gathering at the Annual Conference

"The REALTORS® Conference & Expo is real estate's top networking conference. Nearly 20,000 professionals gathered to share information and learn about cutting edge resources."

Frank Sibley, NAR Senior Vice President, Communications & Convention

In November, REALTORS® from across the country gathered again to attend the 2008 REALTORS® Conference & Expo in Orlando, Fla.

Consistent with the conference's theme, Destination Success, NAR shattered a new record. Attendees awarded NAR an all-time high, overall satisfaction score of 4.67 (out of a possible 5.00).

The NAR Leadership Team kicked things off with an inside look at recently elected U.S. President Barack Obama. In addition to the 59 ½ Minutes program, there was a forum that also looked at the recent presidential election. Attendees also enjoyed other great insights from world-class speakers, such as Lance Armstrong, Joe Theismann and Lee Woodruff.

At the governance meetings, committee leaders and board members laid out a landmark plan to stimulate housing and the economy. The REALTORS® Conference & Expo also marked the official charter of the REALTORS® Federal Credit Union.

All together, the REALTORS® Conference & Expo offered plenty of new opportunities for REALTORS® to help improve their businesses in a challenging environment. For example, the new Exhibitor Presentation Theater and the NAR booth presented learning opportunities for REALTORS® right on the show floor.

1944 Convention cancelled in support of war effort

1949 Patent and trademark offices approve "REALTOR®" and "REALTORS®" terms

1956 REALTOR® Week established

1962 First national advertising and PR campaign launched

1969 RPAC is founded

REALTORS® Political Action Committee
Your Best Investment In Real Estate

1972 Name changed to National Association of REALTORS®

1973 Establishes new block "R" logo

REALTOR®

1974 Acquires current headquarters building at 430 N. Michigan Avenue in Chicago

1989 NAR approves "The Voice for Real Estate"

Completing the Code of Ethics Training

As 2008 drew to a close, NAR accomplished one final milestone. On December 31, 2008, REALTORS® successfully completed the second four-year cycle of the Code of Ethics training.

As with the previous cycle, many NAR members completed the course online, allowing them to stop and restart the course at their convenience within a 30-day time period.

During this cycle, NAR added a new series of videos, "Code of Ethics – REALTORS® Pathway to Professionalism," to better explain particular articles to the Code of Ethics.

> "With 99 percent of members completing the training, we are confident that REALTORS® will continue to set the standard for professionalism in the real estate business for another 100 years."
> *Dick Gaylord, 2008 NAR President*

Another great reason to celebrate, All Together, as we enter a new year United Toward Tomorrow!

DOJ Settlement

After two long years of battling the U.S. Department of Justice over our Internet listing display policy, NAR reached an agreement with the DOJ to settle the case on May 27, 2008. The agreement allowed NAR to focus its attention and resources on the most pressing issues facing REALTORS® and consumers – specifically, a changing market and a growing credit crisis.

On November 18, 2008, U.S. Federal District Court Judge Matthew F. Kennelly gave final approval to the settlement. The final judgment preserved the multiple listing service as a means of broker-to-broker cooperation.

1992 Dorcas Helfant becomes first woman president of NAR

1996 NAR launches REALTOR.com

1998 Public Awareness Campaign launched

2000 Good Neighbor Awards created

2001 HOPE Awards established

2004 NAR breaks 1 million membership mark and opens new building in Washington, D.C.

2007 NAR launches Second Century Initiative

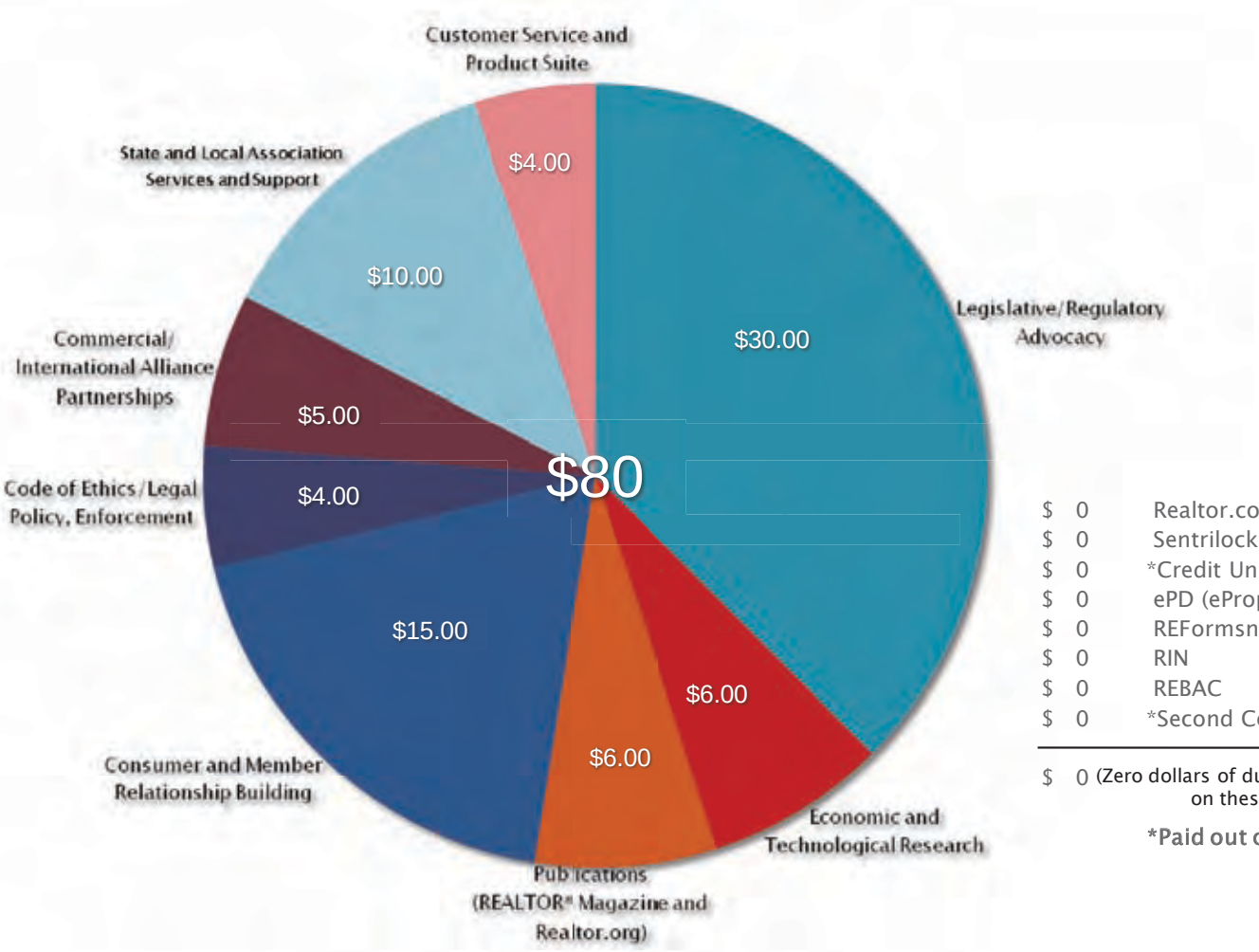
2008 NAR celebrates centennial

How the $80 Dues Increase is Allocated

Finally, helping REALTORS® innovate, advocate and celebrate would not be possible without superior financial accountability.

In 2008, NAR dues revenue and membership statistics held steady despite economic conditions. NAR and its members benefited from solid returns from non-dues revenue programming. Investment transactions also remained reliable for 2008. Prudent expense management was another factor that resulted with NAR again finishing in a favorable ratio of revenues, well in excess of expenses.

Below is a presentation of NAR's revenues and expenses for 2008.



$ 0	Realtor.com
$ 0	Sentrilock
$ 0	*Credit Union
$ 0	ePD (ePropertyData)
$ 0	REFormsnet
$ 0	RIN
$ 0	REBAC
$ 0	*Second Century Ventures
$ 0	(Zero dollars of dues increase spent on these items)

*Paid out of Reserves

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